JOURNEY OF CHANGE III

Department of Veterans Affairs
Veterans Health Administration

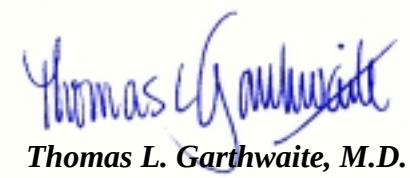
CORPORATE REPORT AND STRATEGIC FORECAST

FOREWORD

The VA health care system has undergone a dramatic transformation. Between 1995 and today, we have made measurable and significant progress in improving the performance of our system. Our performance data demonstrate improved access, quality, safety, patient satisfaction, efficiency, and accountability.

Our nature is to plan to do what we can imagine based on what we know today. History has proven that we will underestimate the magnitude and types of change that will occur. Five years ago, few of us would have believed that Veterans Health Administration could have come this far.

This volume, *Journey of Change III*, describes the progress we have made in 1998 and 1999. In addition, it provides a framework for continued improvements into the future. Its projections may be too conservative. We look forward to exceeding today's vision and discovering what is truly possible.



Thomas L. Garthwaite, M.D.
Deputy Under Secretary for Health

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INTRODUCTION

The purpose of *Journey of Change III* (*Journey III*) is to

- Reaffirm the strategic direction articulated in *Vision for Change* and *Prescription for Change*
- Present the 2000 VHA Strategic Framework
- Highlight 1998 and 1999 accomplishments
- Integrate network strategic plans with related national goals and strategies

1998 and 1999 witnessed the continued transformation of health care in America. Events such as mergers, changes in health care financing, provision of new services, new collaborative arrangements and new technologies impacted the evolving marketplace. The insistent demands for cost containment and greater accountability that have been the driving forces of change in the marketplace have been replaced by an emphasis on leadership in health care quality.

Veterans Health Administration (VHA) has worked diligently to accomplish the transformation set in motion by *Vision for Change* and *Prescription for Change*. The "new VHA" has emerged as an organization characterized by a fully coordinated continuum of care, a predictable and consistent level of care, and achievement of the performance outcomes it sets for itself to improve patient care and safety, access, customer satisfaction, and cost.

The implementation process has focused on reengineering VHA's operational structure, diversifying its funding base, streamlining processes, implementing "best practices," improving information management, reforming eligibility rules, expanding contracting authority, and changing the culture in which VA health care is delivered. The success of these initiatives has positioned VA to compete in the broader and evolving health care marketplace. Throughout this rapid transformation, VHA has made health care quality the guiding principle of its ongoing implementation and institutionalization efforts.

To continue the transformation of the "new VHA," VHA has adopted a four-point quality success strategy:

- Patients as partners
- Five star service
- Easy access
- Consistent and predictable quality

QUALITY AND CORE VALUES

VHA will continue the transformation of the "new VHA" as outlined in *Vision for Change* and *Prescription for Change* and will work to formally consolidate and institutionalize the new ways of doing business. Expansion and standardization of quality assessment and measurement programs will be the guiding strategy for this process. Quality enhancement efforts will center on performance improvement in:

- Personnel
- Clinical care activities

- ❑ Internal review
- ❑ External review and oversight
- ❑ Technology management
- ❑ Patient reported outcomes
- ❑ Education
- ❑ Research
- ❑ Change management

Goals for each aspect of the quality improvement program are articulated in *Journey III*. Strategic targets for quality management will be part of all VHA programs. It is expected that achievement in these areas will form the basic standards of quality that can help national quality management efforts for the private sector. As a foundation for these quality improvement efforts, in 1997 VHA validated a basic set of corporate held core values (see Table 1). These values, defined through a process of synthesizing individual program and facility values and wide discussion with members of the VHA community and stakeholders, represent a consensus of key core values held by VHA staff.

Table 1

VHA Core Values

Trust	Means having a high degree of confidence in the honesty, integrity, reliability and sincere good intent of those with whom we work, the services that we provide, and the system of which we are a part. Trust is the basis for the caregiver-patient relationship and is fundamental to all that we do in health care.
Respect	Means honoring and holding in high regard the dignity and worth of our patients and their families, our co-workers, and the system we are a part of. It means relating to each other and providing services in a manner that demonstrates an understanding of and a sensitivity and concern for each person's individuality and importance.
Commitment	Means dedication and a promise to work hard to do all that we can to provide service to our co-workers and our patients that is in accordance with the highest principles and ethics governing the conduct of the health care professions and public service. It is a pledge to assume personal responsibility for our individual and collective actions.
Excellence	Means being exceptionally good and of the highest quality. It means being the most competent and the finest in everything we do. It also means continually improving what we do.
Compassion	Means demonstrating empathy and caring in all that we say and do. It means sharing in the emotions and feelings of our co-workers, our patients and their families, and all others with whom we are involved.

These five core values guide all national planning and program management and are reflected in VHA organizational behavior. When taken with VHA's "Domains of Value," they constitute true north on the compass to direct VHA's continued Journey of Change. First and foremost, these values are reflected in the approach to quality improvement.

Strategic Planning

Two elements underpin VHA's strategies: (1) development of corporate and network strategic plans, and (2) corporate and network strategic management. These elements will evidence the implementation of program evaluation and monitoring systems and the identification and dissemination of key strategic initiatives. Innovation and program enhancement will be widely encouraged and assessment and utilization of lessons learned will continue to be encouraged and rewarded.

Operating strategies for reaching or exceeding the national strategic targets are highlighted and expectations for performance are articulated. The relationship of prior accomplishments and expected achievements to the VA Strategic Plan and the furtherance of "One VA" are also outlined.

Based on a foundation of the core values and the five domains of value, VHA programs articulate seamlessly with the mission, goals, objectives, and performance goals in VA's Strategic Plan.

VHA plan components of strategies, performance measures, and VISN operating strategies relate to the VA strategic plan elements and begin to provide the detail of how VA will achieve its strategic direction in health care delivery. The VISN operating strategies included as part of *Journey III* provide a clear framework within which VHA strategic targets will be achieved.

Journey III summarizes 1998 and 1999 accomplishments and sets the strategic direction for 2000 – 2005. As it goes forward, VHA will continue to focus on aspects of quality and performance: internal and external quality reviews; implementation of clinical guidelines and performance indices for chronic care, prevention, and early detection with special attention to VHA special emphasis programs; patient and employee education and training; research; emergency management; and change management.

In addition, VHA's strategies focus on enhancing and expanding information systems both at the clinical and at the administrative level, integrating IT systems with the Veterans Benefits Administration to serve veterans as "One VA," and increasing access to all veterans who choose VA for their health care.

The "new VHA" sets the standard for national health care quality and provides cutting edge health care services, research, and education to optimize the health status of the Nation's veterans.

CHAPTER 1

STRATEGIC MANAGEMENT FRAMEWORK

This chapter presents VHA Strategic Management Framework in three sections:

- Current Environment
- "One VA": The Department of Veterans Affairs Strategic Plan
- VHA Strategic Planning Framework

CURRENT ENVIRONMENT

Missions

The primary mission of VHA is to serve the health care needs of America's veterans. This is accomplished through a comprehensive, integrated health care system that provides excellence in health care value, excellence in service as defined by its customers, and excellence in education and research. VHA is also an organization characterized by exceptional accountability that strives to have its employees view the organization as an employer of choice. Two of its missions present unique opportunities for VHA to contribute to the Nation's health care system: education and research. VHA is the largest single provider of health professions training in the world. VHA's research program is one of the largest and most productive research organizations in the country. While focused directly on benefiting veterans, VHA research program also makes significant contributions to medicine and health care worldwide. VHA also has a mission to provide contingency support to the Department of Defense (DoD) and the Public Health Service during times of disaster or national emergency, and is one of the government's principal assets for responding with medical assistance to large-scale national emergencies.

Customers

VHA defines its customers as veterans and their families. In select situations, caregivers and other staff are considered customers because they rely on elements of the organization to provide them with information or services that are, in turn, used to provide health care. VHA continues to focus its energy, first and foremost, on veterans and their families.

Stakeholders

VHA has numerous stakeholders who have a direct interest in the delivery of quality health care to veterans. They include:

- Veterans and their families
- Congress and the Administration
- Health care professional trainees
- Researchers
- VHA/VA employees and staff
- Veteran Service Organizations
- Academic affiliates
- Local communities
- Public-at-large
- State/County veterans offices
- State veterans homes
- Contract providers

VHA's Strategic Journey

In the decade of the 1990s, VHA's ability to carry out its primary mission to serve the health care needs of the Nation's veterans was compromised by the changes already underway in the health care industry. The 1990s witnessed a transformation of health care in America that was driven by insistent demands for cost containment and greater accountability. A dynamic tension between health care costs and quality dominated the market. As providers struggled to cope, the decade witnessed numerous strategies employed to reconcile the competing demands such as mergers, cost control initiatives, new services, new collaborative arrangements, and new technologies. The transformation is expected to continue impacting the health care market in the new millennium.

VHA's strategy for this health care transformation was outlined in the *Vision for Change* and *Prescription for Change*. These seminal documents laid the groundwork for changing VA health care from a system dominated by inpatient hospital care to a patient-centered, outpatient-based system with strong community links. While profound changes have occurred in the VA health care system in the last decade, even more change is expected in the future as VHA strives to find more efficient ways to enhance quality, increase access, improve service satisfaction, and optimize patient functioning. The goal remains to achieve a fully coordinated continuum of care, a predictable and consistent level of care, and a system characterized by continuous improvement in patient care and safety, cost, access, and customer satisfaction.

VHA's journey to date has been described in two documents titled *Journey of Change I* and *Journey of Change II*, both of which outlined an evolving strategic direction. Continuing refinements to the strategic direction outlined in *Journey II* include: (1) a full integration with the VA Strategic Plan and (2) a focus on critical strategic initiatives including:

- Complete integration that ensures a full continuum of care
- A deepening focus on quality and patient safety
- Full implementation and consolidation of strategic management programs
- Continued institutionalization of best practices including patient safety
- Integration of strategic planning and management processes

During these times of change, VHA's future will be enhanced by forging relationships with others, by contributing a broad array of services and resources to the national health care system, and by assuming leadership positions in areas of special expertise.

"ONE VA": THE DEPARTMENT OF VETERANS AFFAIRS STRATEGIC PLAN

VA strategic planning is grounded in the commitment to "One VA." A major goal for VA is to organize the strategic planning and programs of its component parts (VHA, Veterans Benefits Administration, and National Cemetery Administration) to function as a unified organization. The VA Strategic Plan integrates state-of-the-art planning techniques into a process that will build a strong and resilient strategic base for the future. The key components of that planning process include developing:

- Measures of program efficiency (unit cost)
- Measures of program outcomes
- Information systems that provide management data for each measure
- Benchmark levels of performance
- Links between performance measures and budget
- Links between organizational performance and employee performance

Other areas of focus for VA strategic planning include the use of reengineering/restructuring and consolidation options, promotion of total quality improvement principles, and advances in technology to enhance current VA programs.

VA has established five corporate goals for the next strategic planning cycle, and all five apply directly to VHA programs:

- Restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families
- Ensure a smooth transition for veterans from active military service to civilian life
- Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation
- Contribute to the public health, socioeconomic well being and history of the Nation
- Create an environment that fosters One VA world-class service to veterans and their families through the effective management of people, technology, processes, and financial resources

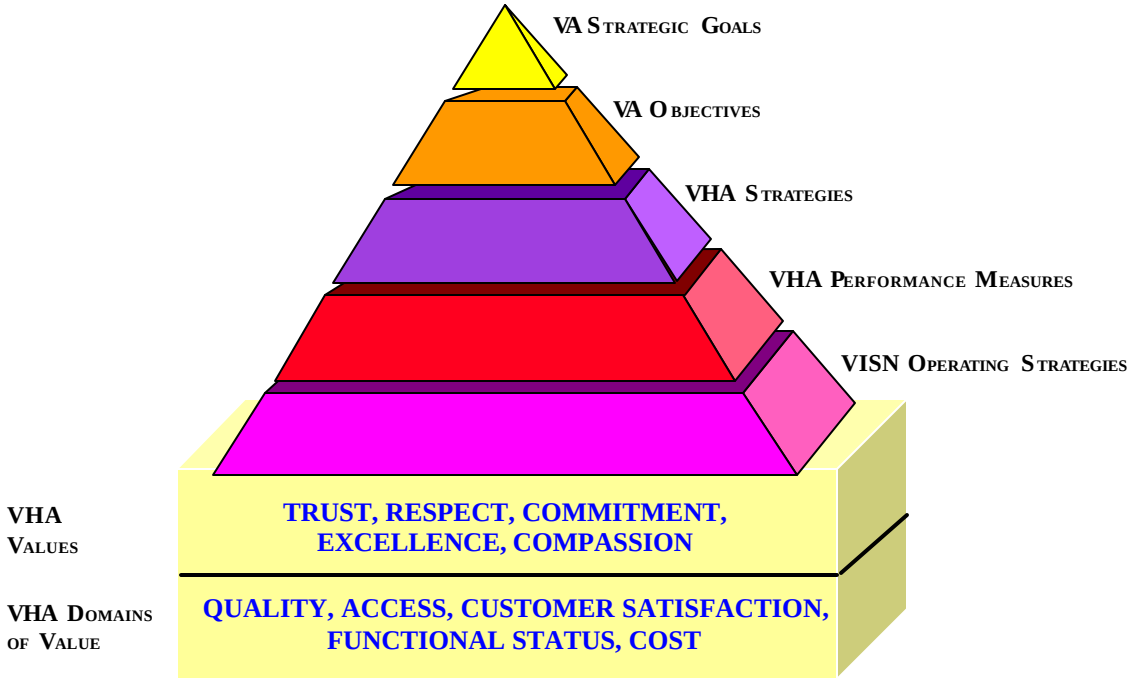
VHA's Strategic Planning Framework

Linkage to Department Plan

VHA has developed a Strategic Planning Framework consisting of strategies, 5-year performance targets, and annual performance measures that are linked to the Department-wide goals and objectives. The emphasis on the flow from Department goals and objectives to VHA strategies and measures is illustrated in Figure 1.1 (VHA Strategic Planning Framework). This format is also the organizational structure for the VA Strategic Plan.

Figure 1.1

VHA Strategic Planning Framework



VHA's Strategic Planning Framework aligns all VHA planning activities with the VA strategic goals and objectives and re-casts planning into a simplified 4-tiered structure of VA strategic goals, VA objectives, VHA strategies, and VHA performance measures. VISN operating strategies are the means by which performance measures will be achieved across the VISNs.

VHA Strategies

VHA strategies are aligned under the VA objectives in the VA Strategic Plan. These strategies, in turn, are aligned with outcome-oriented performance measures. The following lists some of the current strategies, however the list is always evolving:

- **Minimize the proportion of patients including special populations of veterans whose functional status decreases as they age**, as assessed by a standardized and validated instrument. VHA treats an increasingly aged population, and functional status tends to decrease as a person ages. Minimizing the decrease in functioning, or attaining the highest level possible, as opposed to removing the pathological condition, is an important domain of medical treatment. Functional status is also being monitored for special populations of veterans. Data on functional status were collected for 1999. The baseline change for 1999-2000 will be computed after data collection for 2000 is completed. Further data collection in subsequent years will be used to make comparisons to the baseline period.
- **Successfully transition cohorts of hospitalized patients to appropriate community living arrangements**.
- **Provide eligible veterans effective readjustment counseling** for psychological war trauma and/or military-related sexual trauma, in a manner that results in positive consumer feedback.
- **Ensure a consistent delivery of health care by implementing standard measures** that are based upon the provision of evidence-based care that focuses on chronic diseases, prevention, and use of clinical guidelines. This strategy depends on reviews by the External Peer Review Program. Advances in VHA data management may, in time, allow alternative means of collection of data for this strategy.
- **Ensure that patient clinical information is available across sites of care**. Patients increasingly seek and receive VA care at multiple sites. They may receive primary care at community-based outpatient clinics and specialty/inpatient care at one or more medical centers. Timely access to clinical information by VA staff from multiple sites is paramount to ensure prompt service, continuity, and quality care. In addition, providers need a more efficient means to document care. Telemedicine can improve timeliness and quality of care for veterans, maximizing remote provider consultation.
- **Continuously improve the safety of VA health care**. This strategy will depend on development of a system to monitor both safety-related events and the culture of safety within VA medical facilities. VHA will identify key drivers of the patient safety culture in VA medical facilities through surveys focused on improving the culture.
- **Improve the overall health of veterans by focusing on special populations**.
- **Increase the proportion of research projects that are demonstrably related to the health of veterans** or to other Department missions. Among the external influences that may affect the future direction of the Research and Development program are the Congress and advisory committees.
- **Increase positions in primary care training**. Changes in VHA's academic training programs will be affected by its ability to monitor trends in medical education and by its ability to remain a desirable academic training partner. The future of American medicine, and of VA medicine as well, is shaped by scientific, social and economic trends that operate virtually independent of the VA health care system.

- **Provide an educational and training experience for medical residents** and other trainees that is perceived as comparable to, or superior to, their other academic training opportunities. Achievement of this strategy will depend on development of a survey methodology that can provide the data needed to assess trainee satisfaction.
- **Ensure that VHA develops, plans, and maintains readiness as required by Public Law 97-174** and that it implements the Memorandum of Understanding (MOU) between VA and DoD. This strategy requires close coordination between VA, DoD, and National Disaster Medical System (NDMS).
- **Enhance access to clinical care for enrolled veterans**. This strategy is focused on the waiting time goals and development of telephone triage systems.
- **Obtain feedback from the veteran user population** on their satisfaction with service. Customer surveys and focus groups are essential to achieving this strategy.
- **Reduce costs and improve the revenue stream for the health care system**. Shifting the focus of health care delivery from inpatient to outpatient care is a key component of VHA strategy. To successfully accomplish this will require reallocating a significant percent of resources to ambulatory care. Such a shift is contingent upon successful restructuring, as well as upon future need for inpatient care. In addition, it is expected that bed days of care will continue to decline, and that, on the basis of historical experience, the system will be able to meet projected demand arising from an expanded and improved eligibility system. Further gains will depend upon support from external stakeholders and VHA's ability to provide the tools and create the cultural climate necessary to bring about extensive changes in clinical processes. Continuing the trend of increasing revenue growth from non-appropriated sources will require a substantial increase in medical care recoveries, medical sharing, and other reimbursements.

VHA Performance Measures

The VA Strategic Plan describes over 300 performance measures for the Department, which includes 51 performance measures for VHA. These measures are an essential component of VHA's strategic management system. They are continuously reviewed and modified to reflect the increased emphasis on quality, strategic planning, and best practices. They also provide the underpinnings for understanding how the performance targets articulated in the VA Strategic Plan will be achieved.

The 14 strategies and 51 performance measures are the essential components of VHA's strategic management system. They have been incorporated in both the "One VA Strategic Plan" and VHA's annual Budget and Performance Plan. Below is an abridged list of VA Goals and Objectives with associated VHA Strategies and Performance Measures.

I. **VA STRATEGIC GOAL:** Restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families.

VA OBJECTIVE 1.1: Maximize the physical, mental, and social functioning of disabled veterans and special populations of veterans by assessing their needs and coordinating the delivery of health care, benefits, and services.

VHA Strategy 1.1.1: Assure that veterans, including special populations of veterans, achieve maximum functional potential.

VHA Performance Measures:
Minimize decrease in functional status.
Increase administration of initial and follow-up Addiction Severity Index (ASI).
Increase administration of Global Assessment of Functioning (GAF) for mental health patients.

VHA Strategy 1.1.2: Transition veterans to community arrangements.

VHA Performance Measures:
Increase average daily census in skilled community nursing care.
Provide support for assisted living (AL) through pilot program.
Provide increased availability of home and community based care.
Increase independent living arrangements for homeless veterans.
Increase employment for homeless veterans.
Increase the number of homeless veterans treated in the VA health care system.
Maintain proportion of discharges from Spinal Cord Injury (SCI) centers to non-institutional settings.
Increase Traumatic Brain Injury (TBI) patients discharged to independent living.

II. VA STRATEGIC GOAL: Ensure a smooth transition for Veterans from active military service to civilian life.

VA OBJECTIVE 2.1: Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of benefits and services during transition.

VHA Strategy 2.1.1: Provide effective readjustment counseling.

VHA Performance Measure:
By 2005, 95% of veterans using Vet Centers will report being satisfied.

III. VA STRATEGIC GOAL: Honor and serve veterans in life and memorialize them in death.

VA OBJECTIVE 3.1: Improve the overall health of enrolled veterans including special populations of veterans through high quality, safe, and reliable health services.

VHA Strategy 3.1.1: Ensure the consistent delivery of health care.

VHA Performance Measures:
Increase the scores on the Chronic Disease Care Index.
Increase the scores on the Prevention Index.
Increase the provision of palliative care services.
Implement primary care.

VHA Strategy 3.1.2: Improve the availability of clinical information.

VHA Performance Measures:
Improve timely access to patient information.
Increase the number of VISNs using remote telemedicine capabilities to enhance access to care.

VHA Strategy 3.1.3: Continuously improve the safety of VA health care.

VHA Performance Measure:
Improve the culture of Patient Safety in VA medical facilities.

VHA Strategy 3.1.4: Improve the health of special populations of veterans.

VHA Performance Measures:
Provide treatment for patients with Hepatitis C.
Increase referrals of diabetic patients to a foot care specialist.
Reduce the percentage of patients who use tobacco products.
Improve the mammography examination rate.
Improve cervical cancer screening examination rate.
Each medical facility will have a MD trained in former POW needs.
Each medical facility will have a MD trained in Gulf War veteran needs.
Improve the rate of prophylaxis for HIV-related, opportunistic infections.
Monitor physical restraints for nursing home patients.
Increase number of months of follow-up for patients with Post Traumatic Stress Disorder (PTSD).
Increase follow-up for mentally ill homeless veterans.
Increase mental health services after the first PTSD visit.

IV. VA STRATEGIC GOAL: Contribute to the public health, socio-economic well being, and history of the Nation.

VA OBJECTIVE 4.1: Advance VA medical research and development programs to better address the needs of the veteran population and to contribute to the Nation's knowledge of disease and disability.

VHA Strategy 4.1.1: Increase research projects related to the health of veterans.

VHA Performance Measures:
99% of research projects will be peer-reviewed in a merit-based competition.
100% of research projects will be relevant to VA's health care mission.

VA OBJECTIVE 4.2: Ensure an appropriate supply of health care providers for veterans and the Nation through sustained partnerships with the medical education community.

VHA Strategy 4.2.1: Shift specialty resident positions to primary care.

VHA Performance Measure:
Increase the percentage of residents trained in primary care (Category I).

VHA Strategy 4.2.2: Training will be equal to or exceed other academic training.

VHA Performance Measure:
Residents will rate training as comparable or superior to other training.

VA OBJECTIVE 4.3: Improve the Nation's response in the event of a national emergency or natural disaster by providing timely and effective contingency medical support and other services.

VHA Strategy 4.3.1: VHA will maintain readiness as required by PL 97-174.

VHA Performance Measure:
Federal Coordinating Centers will do one casualty exercise every three years.

V. VA STRATEGIC GOAL: Create an environment that fosters One VA World-Class Service to veterans and their families through the effective management of people, technology, processes, and financial resources.

VA OBJECTIVE 5.4: Improve VA's overall governance, operational management, and access to benefits and services to meet or exceed the expectations of veterans and their families, while ensuring full compliance with applicable laws, regulations, and financial commitments.

VHA Strategy 5.4.1: Expand access to clinical care.

VHA Performance Measures:
Veterans referred from primary care will receive a specialist appointment in 30 days.
Veterans will receive an initial appointment in primary care within 30 days.
Veterans with scheduled appointments will be seen within 20 minutes.
Expand to 659 by 2003 the number of community-based outpatient clinics.
Enrolled veterans have access to telephone care 7 days-a-week, 24-hours a day.

VHA Strategy 5.4.2: Obtain feedback from the veteran user.

VHA Performance Measures:
Increase ratings of health care service as very good or excellent.
Increase ratings of the quality of VA health care.
Increase the percentage of blind rehabilitation patients who are satisfied or completely satisfied.
Increase SCI respondents who rate their care as very good or excellent.
Increase satisfaction with VA-issued lower extremity prosthetic limbs.
Reduce percentage of those reporting coordination of care problems.
Reduce number of problems reported on courtesy.

VHA Strategy 5.4.3: Reduce costs and improve the revenue stream for health care.

VHA Performance Measures:
Increase the number of unique patients by 20%.
Reduce the average costs per patient by 30%.
Increase medical care cost recoveries, Medicare and other sharing revenues.

VISN Operating Strategies

This final step on VHA's strategic planning framework represents the specific actions that VISNs take to achieve the strategies assigned to the performance measures. Because performance results necessarily vary among the 22 VISNs, different operating strategies may be required to achieve the targets assigned to individual measures. Therefore, there is no requirement that VISN operating strategies be the same for each VISN. In the aggregate, however, the results of the VISN actions will be reflected in VHA's performance.

CONCLUSION

These strategies and performance measures constitute VHA's compass to the future. They guide all national planning and are reflected in every aspect of daily operations. They are in keeping with VA management strategies and remain the clear focus of VHA strategic planning.

CHAPTER 2

VA HEALTH CARE QUALITY MANAGEMENT

VHA strives to improve quality of care through a comprehensive performance management system that aligns its vision and mission with quantifiable strategic goals, defines measures to track progress in meeting those goals, holds management accountable for results through performance agreements, and advances quality within the context of a full continuum of patient-centered care, while maintaining sound resource management. Improved quality is the result of actively managing performance. This chapter covers VHA's highlights and expectations for its (1) quality management framework, (2) guiding principles approach to quality management, (3) blended strategy for effecting quality improvement, (4) implementation of nationally approved quality indicators, and (5) accomplishments and goals for specific outcomes. The highlights present efforts and initiatives by VHA and individual VISNs that ensure veterans receive the highest quality health care available.

STRATEGIC FRAMEWORK FOR QUALITY MANAGEMENT

In 1995, VHA embarked on a transformation of its health care system. This transformation is grounded in a mission that calls for improving the health of the served population and a vision that calls for a continuum of high quality health care that is convenient, responsive, caring, and provided at a reasonable cost.

At the center of VHA's transformation is a quality framework composed of ten dimensions that cover a wide array of activities designed to assure that VA health care is second to none.

These dimensions/strategies are (see Appendix B for specific tactics):

- Personnel / To attract and retain the best people possible
- Clinical Care Activities / To employ clinical care activities that increase the likelihood of achieving desired health outcomes
- Performance Indicators / To measure and monitor progress in achieving desired health outcomes
- Internal Review & Improvement / To engage all levels of the organization in both routine and event-triggered cycles of improvement
- External Review & Oversight / To enlist impartial and independent review of care
- Technology Management / To optimize use of technology to achieve desired health outcomes
- Patient-Reported Outcomes / To optimize patient and patient family involvement in the design and delivery of health care services
- Education / To prepare the current and future health care work force to deliver high quality health care and to actively participate in improving care
- Research / To generate new knowledge that facilitates improved health outcomes
- Change Management / To actively manage change to achieve strategic goals

A coordinated system of health care can be achieved by vertical and/or virtual integration. The success of health care systems of the future will depend on their ability to integrate and manage information. Health care must reorient itself to be more population-directed, community-based and health promotive. Health care must become more accountable and responsive to both those who purchase it and those who receive it. Medical education and research are accountable public goods.

Plans for 2000 - 2005

- Establish new locations for treating veterans closer to home.
- Shift resources to support outpatient care and realignment of infrastructure.
- Improve employee satisfaction in headquarters, VISNs and field.
- Expand research for veterans and the general public.
- Ensure trainee satisfaction throughout VA.
- Improve VA response to emergencies.

1998 & 1999 Achievement Highlights

- VHA articulated and enhanced the strategic framework for quality management:
  - Implemented a website for the strategic framework for quality management that is accessible to the entire VA system.
  - Involved program officials in describing their components of the framework.
  - Incorporated the framework in the Network Directors' performance agreements.
- Developed clinical practice guidelines that are showing demonstrable system-wide improvements in measures of clinical care quality outcomes.
- Implemented VHA Quality Scholars Program - an initiative that educates physicians in quality improvement while developing their capacity for leadership in quality improvement over a two-year fellowship period.
- Designed and implemented the Kenneth W. Kizer, MD, MPH Quality Achievement Recognition Grant based on Malcolm Baldrige Criteria that recognizes VISNs that achieve outstanding results through a systems approach to the management of quality.
- Developed clinical practice guidelines' "Champion List" for each guideline by facility. (VISN 18)

Guiding Principles of Quality Management

VHA's approach to quality management is predicated on a number of principles and precepts. The following are key among them.

- **VHA is committed to provide the best possible quality of care.** This means care that is objectively comparable or care that is better than that provided in the non-VA sector across the country.
- **Improved quality is the result of actively managing performance.** This requires a structured process for systematic measurement, monitoring, and evaluation of clinical activities, their outcomes, and their improvement. Leadership based on sound organization processes should result in the identification or development, as necessary, of evidence-based performance guidelines or standards which represent best practices in health care.

- **Quality management is not a separate and distinct program.** It is an essential aspect of all processes and practices. All institutional processes, practices, and policies contribute either directly or indirectly to the quality of care provided. Therefore, all organizational processes, practices, and policies must be continually reviewed, analyzed, and refined in light of outcomes and their relationship to the mission, vision and goals of the organization.
- **Broad-based, continuous quality improvement is an essential organizational imperative.** The process of continuous improvement is an iterative process which is analogous to a long journey involving continuous self-assessment, learning, and change.
- **Improving quality and patient safety requires commitment and involvement at all levels of the organization and by all staff.** This commitment begins with the senior leadership in the organization.
- **Resource allocation methodologies should be strategically linked to stated quality improvement initiatives.** Quality and performance objectives should drive utilization of an organization's resources.
- **Health care quality improvement depends on valid and reliable data and information recovery systems.** Data systems for health care organizations should provide readily available, relevant, and reliable information about what services are needed and by whom. Specific information relating to the costs of health care services provided is an essential component of a mature performance management system.
- **Improving cost and utilization of care efficiencies at every level of the organization is best assured by an effective and mature quality and performance management system.** Quality and performance objectives should drive the management of an organization's resources.
- **Those practitioners closest to the site of service delivery most immediately influence quality of patient care.** Therefore, VHA must have proactive, systemwide policies and procedures for measuring, monitoring, and evaluating quality of care at the site of service delivery and for consistently and quickly feeding back relevant information to front-line practitioners. Lessons learned about quality of care should be rapidly disseminated across the organization and operationalized by caregivers.
- **Human knowledge, judgement, and skill are imperfect and vary over time.** Quality-of-care problems most often result from process-related or systems-related failures that allow suboptimal decisions to be made, acted upon, and brought to completion. The inherent nature of human imperfection must be recognized by health care organizations, and processes and systems must be designed to minimize the occurrence of human error by detecting, intercepting, and preventing erroneous actions so that they are not completed.
- **The organizational environment must welcome the unrestricted identification of errors because the system views errors as opportunities for improvement.** Health care delivery organizations must create environments in which practitioners think critically about the processes and technology of care, proactively identify real and potential problems, and aggressively develop and implement needed changes.
- **Achieving high-quality health care is everyone's responsibility.** All members of the health care team have a responsibility to demonstrate leadership in their area of expertise. Practicing physicians must provide active and visible leadership in improving health care quality. Likewise, nurses, representing the discipline with the greatest numbers on the treatment team, must be intricately and extensively involved in all processes that affect the quality of care.
- **Management and utilization of research are an integral part of any high-quality health care system.** The primary mission of a health care organization's research program should be to improve the quality of care provided to its patients. The research program should focus on the needs of the system's users, and organizational policies should facilitate the discovery of new and innovative ways to meet patients' needs. VHA's health services research program should be especially focused on the needs of veterans and on seeking solutions to problems of health care management in the veterans' health care system.

- **Education is an integral part of a high-quality health care system.** Successful organizations that recognize the relationship between job-related knowledge and skills and organizational performance are increasing their investment in employee education and training. The VA health care system plays a substantial role in improving future health care delivery modalities and quality of care by investing in the training and research activities of its health care professionals.

BLENDED STRATEGY FOR EFFECTING QUALITY IMPROVEMENT

To accomplish the goal of system-wide quality improvement, VHA has pursued an operational strategy that combines central policy and goal setting with competition and rewards and that builds upon the professionalism and passion of health care workers to do what is best for patients.

Central Direction

VHA's policy and goal setting efforts consist primarily of defining and setting standards and expectations for quality and other performance, monitoring performance to determine if the standards are being met, and then managing those entities needing improvement. The principal vehicle that has been used to effect these expectations has been executive performance agreements (a.k.a., "performance contracts") between each VISN Director and the Under Secretary for Health (VHA's chief executive officer) and between the Under Secretary for Health and the Chief Officers. The VISN Directors and Chief Officers, in turn, have effected similar performance agreements with their subordinate managers. At present, this performance management methodology is unique to VHA in the federal government, and the approach is being studied by investigators from Boston University as part of a project funded by the National Science Foundation to study large organization change. VHA is one of only two government agencies (NASA being the other) included among the 25 organizations being studied in the project.

Performance Measures

The performance measures for which Network Directors and Chief Officers are held accountable are linked to VHA's strategic goals and are divided among VHA's five specified domains of value. Utilizing these multiple domains and multiple measures in each domain provides an intrinsic check-and-balance system. By collating and promulgating quality information achieved by the VISNs, hospitals, and other care delivery elements and by instituting an array of awards and recognitions for high quality, VHA also hopes to stimulate competition towards improvement among the VISNs and facilities, with the patient benefiting from such competition.

Awards and Recognitions Used by VA

Department of Veterans Affairs Awards

- Robert W. Carey Award for Quality
- Secretary's Award for Excellence (various programs)
- Secretary's Award for Advancement in Nursing Programs
- Scissors Awards
- Heart & Hands Awards

Veterans Health Administration Awards

- Mark Wolcott Award for Clinical Excellence
- David M. Worthen Award for Academic Excellence
- William S. Middleton Award for Research Excellence
- Paul B. Magnuson Award for Rehabilitation Research

Under Secretary for Health's (USH) Awards

- Quality Improvement Awards
- Best Value Awards
- Superior Customer Service Awards
- Strategic Alliance Awards
- Under Secretary for Health Honor Awards
- Under Secretary for Health Award (for program/specialty) of the Year
- Under Secretary for Health Achievement Awards
- Unsung Heroes & Heroines Awards
- Voluntary Service Award for Excellence
- Diversity Awards Program
- Patient Safety Improvement Awards
- Kenneth W. Kizer, MD, MPH Quality Achievement Recognition Grant

External Awards

- National Performance Review "Hammer Awards"
- President's Award for Quality
- Community organization awards (various)
- Professional society awards (various)
- Foundation awards (various)
- Malcolm Baldrige Award

NATIONAL QUALITY INDICATORS AS RELATED TO VHA

An organization must know how it is currently performing in order to determine what it is doing well and where it can improve. While it is understood that there is no one universally accepted method for measuring quality, there are numerous widely accepted benchmarks that are considered indicators of quality health care. By comparing: (1) VHA to others via nationally accepted guidelines and benchmarks, (2) VHA to VHA across the timeline of different fiscal years, or (3) VHA to VHA across the VISNs, VHA can identify successes as well as areas for improvement. In addition to the use of prevention and chronic disease management interventions, VA monitors indicators such as survival rates for selected conditions and surgical mortality rates nationally.

Plans for 2000 - 2005

- Provide clinical data across treatment sites.
- Improve measuring and reporting the outcomes of care.
- Improve the safety of the care environment.
- Expand VA provider's ability to use functional assessment data to improve care.
- Transition veterans from inpatient care to community-based settings.

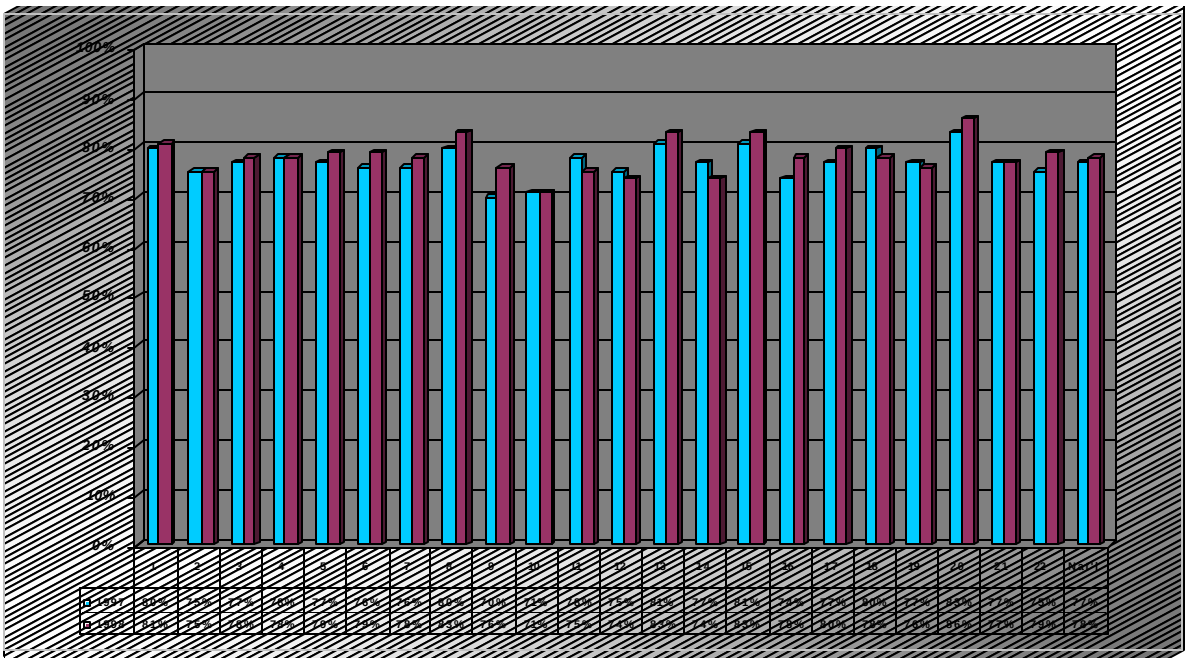
1998 & 1999 Achievement Highlights

Primary Care

- Having the care of each patient coordinated by one individual or a specific group of individuals is an essential element of providing quality care. In VHA, patients are asked whether they know that one person or team is in charge of their care. Chart 2.1, "Primary Care Enrollment," shows the survey results (patients who answered "yes" when asked that question).
- Practice Profiling – Primary Care Management Module (PCMM) was released to the field September 1998. PCMM was modified to easily capture and transmit primary care practitioner information.
- Primary Care Patient Service Line developed a clinical practice guideline manual listing 15 guidelines, accompanying algorithms, and performance measures. (VISN 13)
- VISN Primary Care and Consultative Medicine Committee promoted VISN-wide implementation of evidenced-based pain management protocols. (VISN 4)
- Primary Care Service Line instituted clinical alerts that appear on all primary care health summaries. (VISN 10)

Chart 2.1

PRIMARY CARE ENROLLMENT



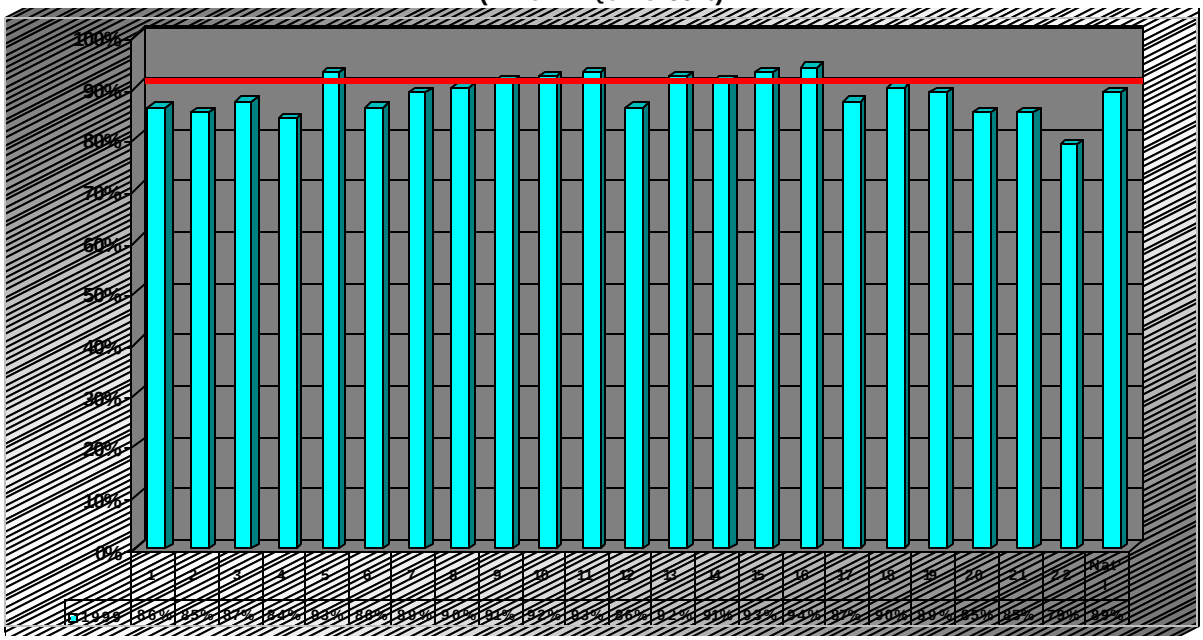
SOURCE: 1998 NETWORK PERFORMANCE REPORT

Chronic Disease Care Index

- VHA made remarkable progress in implementing 13 nationally recognized clinical interventions applicable to five high volume diagnoses (ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity).
- Adherence to interventions was 89% in 1999. Chart 2.2 reflects the national performance as well as the individual VISN performance for 1999. Baseline data is unavailable due to changes in Chronic Obstructive Pulmonary Disease (COPD) Inhaler indicators and lack of data needed to recompute. Table 2.1 describes the 1999 interventions themselves. Chart 2.3 reflects nation-wide implementation of each intervention.
- Established cohort group to facilitate and disseminate "Best Practices." (VISN 16)

Chart 2.2

CHRONIC DISEASE CARE INDEX
VISN IMPLEMENTATION LEVEL OF ALL INTERVENTIONS
(TARGET EQUALS 90%)



SOURCE: 1999 NETWORK PERFORMANCE REPORT

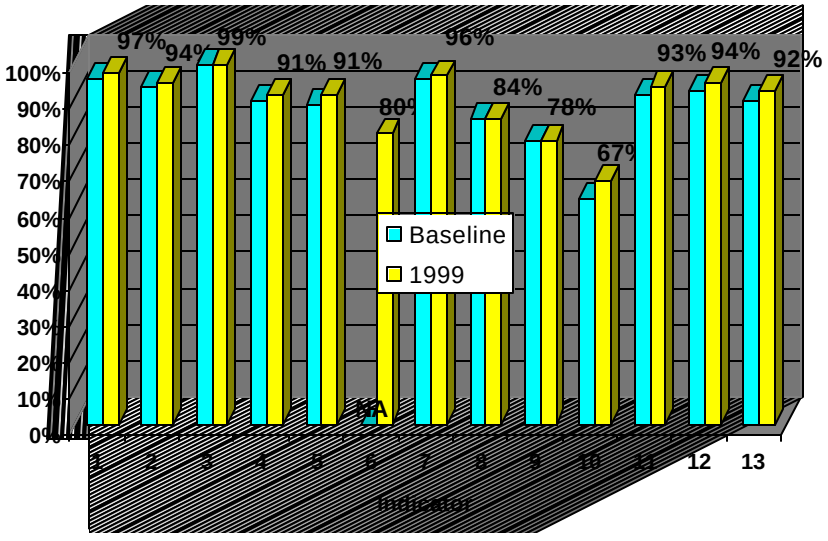
Table 2.1

CHRONIC DISEASE CARE INDEX INTERVENTIONS

DIAGNOSIS	INDICATOR	CLINICAL INTERVENTION
ISCHEMIC HEART DISEASE	1	Administration of aspirin.
	2	Administration of beta blockers.
	3	Documentation of plan to manage cholesterol in the chart of outpatient record.
HYPERTENSION	4	Documentation of counseling about exercise during past two years in appropriate patients with hypertension.
	5	Documentation of counseling about nutrition/weight control during past two years in appropriate patients with hypertension.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	6	Patient was instructed and observed in the use of the inhaler during any inpatient or outpatient encounter.
DIABETES MELLITUS	7	Diabetics other than bilateral amputees with past year documentation of visual inspection of the feet.
	8	Diabetics other than bilateral amputees with past year documentation of examination of pedal pulses.
	9	Diabetics other than bilateral amputees with past year documentation of foot sensory examination.
	10	Diabetics with documentation of past year fundoscopic examination of the retina.
	11	Diabetics with documentation of past year hemoglobin Alc determination.
OBESITY	12	Overweight persons with documentation of nutrition counseling during past 2 years.
	13	Overweight persons with documentation of exercise counseling during past 2 years.

Chart 2.3

CHRONIC DISEASE CARE INDICATORS
NATIONWIDE IMPLEMENTATION LEVEL OF EACH INTERVENTION



SOURCE: 1999 NETWORK PERFORMANCE REPORT

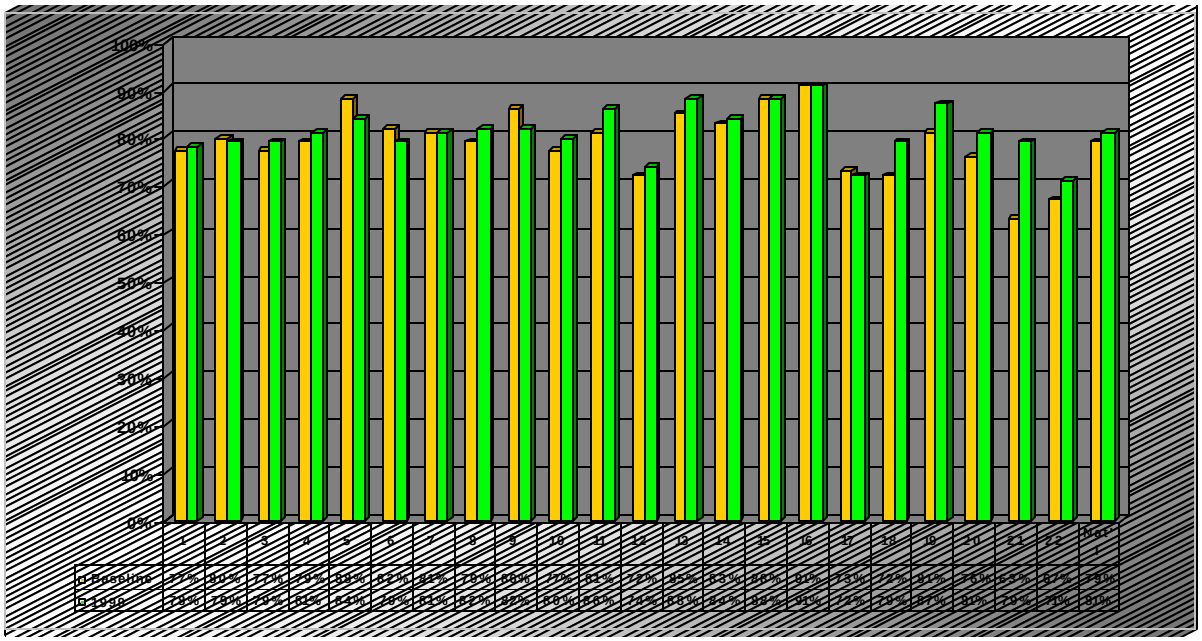
Note: NA for Indicator 6 baseline due to change in definition of indicator.

Prevention Index

- Charts 2.4 and 2.5 demonstrate the success with which VHA has implemented nine interventions such as immunizations, cancer screening, tobacco consumption screening, and alcohol consumption screening that are nationally recognized for the primary prevention and early detection of diseases with major social consequences. (Table 2.2, following Chart 2.4, defines the nine interventions.)
- All VISNs have made significant progress in implementing the interventions, with the highest implementation level at 91% and the lowest at 71% in 1999 compared to a high of 91% and the lowest at 63% in 1998. (See Chart 2.4.)
- Dedicated nurse FTE throughout VISN to call patients who have not been seen within last 2-3 years to offer annual flu immunizations and encourage follow-up health assessment. (VISN 17)

Chart 2.4

PREVENTION INDEX
VISN IMPLEMENTATION LEVEL OF ALL INTERVENTIONS



SOURCE: 1999 NETWORK PERFORMANCE REPORT
NOTE: BASELINE EQUALS 1998

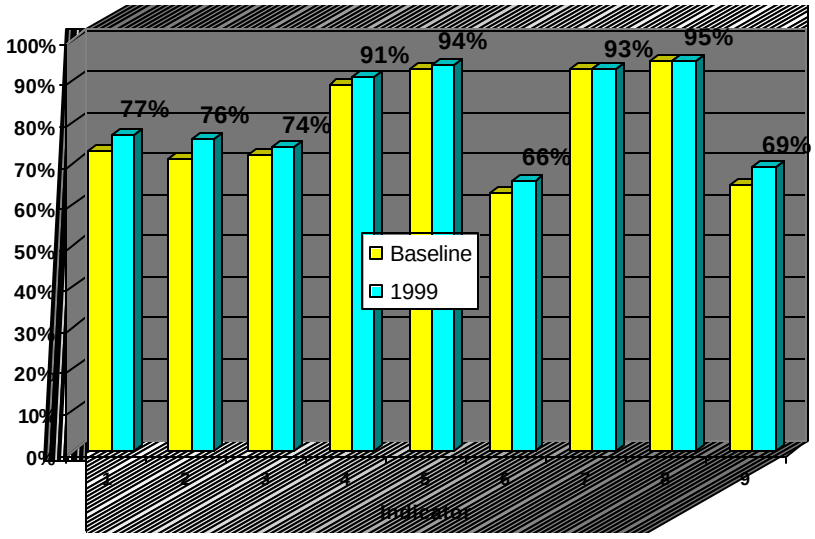
Table 2.2

PREVENTION INDEX INTERVENTIONS

CATEGORY	INDICATOR	INTERVENTION
IMMUNIZATIONS	1	Person age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving pneumococcal vaccine.
	2	Person age 65 or older or at high risk of influenza with documentation of ever receiving influenza vaccine in past year.
CANCER SCREENING	3	Persons age 50 or older with documentation of fecal occult blood screening in the past year or sigmoidoscopy in the past 10 years.
	4	Females age 50-69 with documentation of mammography in past two years.
	5	Females age 65 and younger who have not had a hysterectomy with documentation of receiving a Pap smear in the past three years.
	6	Males age 50 and older with documentation in the chart of past year discussion of risks and benefits of prostate cancer screening.
TOBACCO CONSUMPTION	7	Current smokers whose charts document advice to stop smoking in the past year.
	8	Persons whose charts document screening for tobacco use in the past year.
ALCOHOL CONSUMPTION	9	Persons whose charts document screening for alcohol using a standardized instrument.

Chart 2.5

PREVENTION INDICATORS
NATIONWIDE IMPLEMENTATION LEVEL OF EACH INTERVENTION



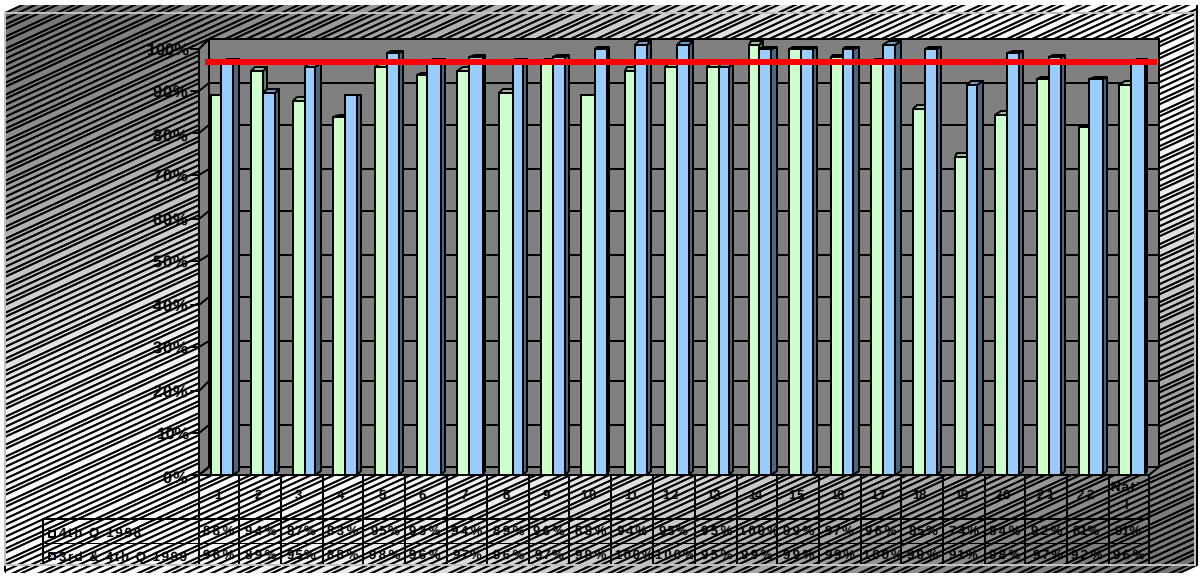
SOURCE: 1999 NETWORK PERFORMANCE REPORT
NOTE: BASELINE EQUALS 1998.

Palliative Care

- An area of health care that is receiving increased attention in the private as well as the public sector is end-of-life planning for terminally ill patients.
- VHA was presented with an award for exceptional work in improving care of those approaching the end of life – the first of its kind – from Americans for Better Care of the Dying.
- VHA developed the Palliative Care Index to track VISN efforts in end-of-life planning for all appropriate patients. The end-of-life planning is incorporated in activities to comprehensively manage the physical, psychological, social, spiritual and existential needs of patients with incurable, progressive illnesses. For appropriate patients with cancer, AIDS, chronic renal failure, chronic heart failure, or chronic obstructive pulmonary disease, the Palliative Care Index indicates the proportion who have documentation of an individualized plan for comprehensive, coordinated end-of-life care services (Chart 2.6).

Chart 2.6

PALLIATIVE CARE INDEX
VISN IMPLEMENTATION LEVEL OF INTERVENTIONS
(TARGET EQUALS 95%)



SOURCE: 1999 NETWORK PERFORMANCE REPORT

ACCOMPLISHMENTS AND GOALS FOR SPECIFIC PATIENT REPORTED OUTCOMES

VHA relies heavily on periodic feedback from customers as to the level of their satisfaction with service - obtained through surveys, focus groups, complaint handling, patient advocates, and Service Evaluation and Action Teams (SEAT). In 1993, VHA established the National Performance Data Feedback Center (NPDFC), which completely transformed the 1972 version of the patient satisfaction survey questionnaire.

VHA developed a partnership with the Picker-Commonwealth Foundation of Boston, Massachusetts, formerly the Picker-Commonwealth Program for Patient-Centered Care. The Picker Institute has been a leader in assessing non-VA patient experiences with health care since 1987. In the non-VA sector, more than 200,000 patients and health care consumers in more than 400 health care institutions have been interviewed using Picker patient satisfaction surveys. The Picker Institute has surveyed patients receiving health care in a variety of settings, including health plans, hospitals, clinics, physician practices, and business/purchasing coalitions.

The NPDFC survey questionnaires are the product of highly trained statisticians with expertise in survey methodology. They target the dimensions of care that patients are most concerned about as validated by VA patients during a series of focus groups held throughout the country.

- Access to care
- Respect for patients' values
- Coordination of care
- Information and education
- Involvement of family and friends
- Physical comfort
- Emotional support
- Transition and continuity of care

Obtain Feedback from the Veteran User Population

The NPDFC sends surveys to patients who have received care in a variety of settings, e.g., inpatient, outpatient, mental health, home-based hospital care, and certain special emphasis programs such as SCI and Gulf War. VHA continues to use non-VA benchmarks drawn from the database compiled by the Picker Institute that represents similar academic and non-affiliated health care institutions across the country.

Plans for 2000 - 2005

- Expand and enhance VA providers ability to use patient survey data to improve patient care.
- Improve health care for special populations.

1998 & 1999 Achievement Highlights

- The 1998 actual levels of achievement for inpatient and outpatient ratings of VHA care as very good or excellent are 65.3% and 64.8%, respectively, as shown in the following tables.

Table 2.3

BY 2003, INCREASE TO 95% THE PROPORTION OF PATIENTS REPORTING VA HEALTH CARE AS VERY GOOD OR EXCELLENT - INPATIENT

1996	1997	1998	1999	2003
65%	65%	65.3%	79%	95%

SOURCE: VHA PERFORMANCE PLAN, 2000

Table 2.4

BY 2003, INCREASE TO 95% THE PROPORTION OF PATIENTS REPORTING VA HEALTH CARE AS VERY GOOD OR EXCELLENT - OUTPATIENT

1996	1997	1998	1999	2003
61%	63%	64.8%	79%	95%

SOURCE: VHA PERFORMANCE PLAN, 2000

- The actual level of "equal or better" ratings rose to 79.3% in 1998, up slightly from a 1997 level of 78.4% (Table 2.5). Patients define excellence according to the degree to which services received match their expectations (Principle 17, *Prescription for Change*, 1996). Extensive efforts are being made to improve quality and consistency across the system.

Table 2.5

INCREASE TO 90 % THE PROPORTION OF PATIENTS WHO RATE THE QUALITY OF VHA HEALTH CARE AS EQUIVALENT TO OR BETTER THAN WHAT THEY WOULD RECEIVE FROM OTHERS

1996	1997	1998	1999	2003
77.9%	78.4%	79.3%	87%	90%

SOURCE: VHA PERFORMANCE PLAN, 2000

Customer Service / Care Management

A Customer Service Standard (CSS) Survey assesses access, education, preferences, emotional support, coordination of care (visit), and courtesy. VHA compares the results of their own survey to a non-VA benchmark from the database of the Picker Institute. A CSS score is the percentage of unfavorable answers received on the questions related to that CSS. CSS scores are computed by first assigning a score of zero (0) to each question answered in a favorable manner and a score of one (1) to each unfavorable answer. The questions related to each CSS are then averaged together to obtain a score for that CSS for each patient. Individual CSS scores are averaged together to obtain VAMC/Network-level scores.

Care management in VA is a process for increasing the likelihood that a patient receives easily accessible, coordinated, continuous, high quality health care. It is that aspect of primary care that coordinates care across all settings, including the home. VA care management is patient-centered rather than disease-specific; the care manager assigned to a particular patient carries out coordination of care for all diseases and all episodes of illness. VA care managers especially focus on the patient in the context of family and community by integrating an assessment of living conditions, family dynamics, and cultural background into the patient's plan of care.

The goal of customer satisfaction is to provide service that will meet or exceed customer expectations.

Plans for 2000 - 2005

- Provide world class customer service to veterans and their families at the Headquarters, VISN and facility level.
- Improve measuring, reporting, and using patient satisfaction information at the Headquarters, VISN, and facility level to improve patient care.

1998 & 1999 Achievement Highlights

- Table 2.6 lists the 1998 and 1999 CSS scores (from the 1999 Ambulatory Care Survey) for each parameter. The lower the score, the higher the patient satisfaction level. VA data is risk-adjusted for VISN and facility differences in age and health status for purposes of internal VA comparisons.

Table 2.6

COMPARISON OF 1998, 1999 VA CUSTOMER SURVEY RESULTS WITH 1999 PICKER SCORES (NON-VA BENCHMARK). LOWER SCORE IS BETTER.

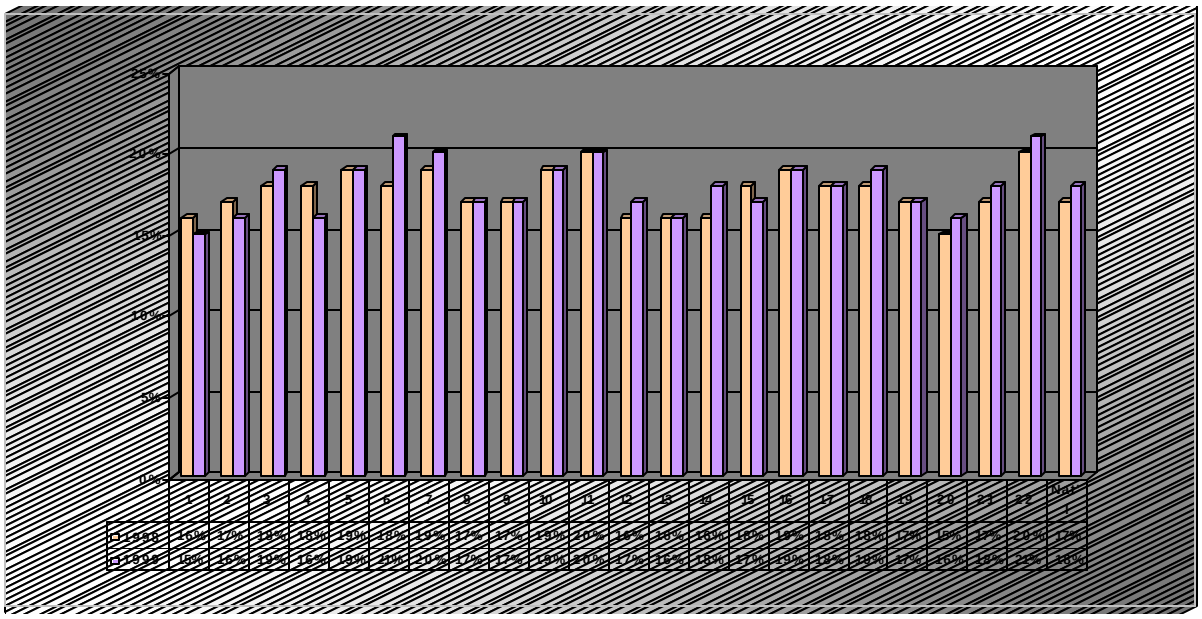
CUSTOMER SERVICE STANDARD	1998 Score	1999 Picker Score (Non-VA Benchmark)	1999 Score
ACCESS	.11	.08	.11
EDUCATION	.27	.21	.31
PREFERENCES	.21	.11	.21
EMOTIONAL SUPPORT	.21	.15	.20
COORDINATION (VISIT)	.17	.06	.16
COURTESY	.07	.05	.07
AVERAGE	**.17**	**.11**	**.18**

SOURCE: 1998 AND 1999 NETWORK PERFORMANCE REPORTS

- In VHA, the percentage of problems reported per patient dropped from 22% in 1997 to 18% in 1999 overall. Chart 2.7 details the 1999 Ambulatory Care Customer Survey results.

Chart 2.7

AVERAGE PERCENTAGE OF PROBLEMS REPORTED PER PATIENT



SOURCE: 1998 & 1999 NETWORK PERFORMANCE REPORT

- Use Health Touch (Kiosk) machines.
- VISN-wide implementation of shuttle services and/or valet parking. (VISN 18)
- Expanded clinic hours to evenings and weekends. (VISN 4, 5, 14)
- Established VISN Forensic Medicine Coordinator to coordinate efforts between DoD/VA for improving compensation and pension examinations and improve customer satisfaction. (VISN 16)
- Developed network patient transfer policy to ensure uniform processes in transfer and/or referral of patients. (VISN 18, 22)
- Adopted network-wide policy and procedure on contraindications for the use of contrast material in patients on Glucophage. (VISN 4)
- Established network-wide “Best Practices” protocols. (VISN 6)

Reviews by Accrediting Organizations

Another major indicator of quality care is approval by a formal body with accreditation or licensing jurisdiction, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

VHA facilities have been reviewed and accredited by JCAHO for many years, and VHA is now actively pursuing CARF accreditation for rehabilitation programs. It has been VHA's historical mission to provide state-of-the-art services for emotionally and physically disabled veterans in need of rehabilitation. Standards published by CARF are consumer-focused, field-driven, and state-of-the-art national standards for rehabilitation.

Although all patients benefit by having VHA facilities and programs meet the standards set by these organizations, care of the special emphasis populations (e.g., spinal cord injury and disorders, amputations, traumatic brain injury) is especially affected by meeting CARF requirements. These efforts support the VA Strategic Plan objective to maximize the functional potential of special populations of veterans, assess their needs, improve the quality of their care, and ensure that access to VA programs and benefits is equitable.

Accreditation by JCAHO is recognized nationally as a symbol of quality and is considered by VA as one of its major external quality reviews. JCAHO accreditation confers recognition that health care organizations meet certain standards of safety and quality. In addition, accreditation confers deemed compliance with the health care quality standards of payors, both public (e.g., Medicare) and commercial. Of the 60 VHA facilities surveyed by JCAHO in 1998, 58 scored 90 or above. The average VA hospital score was 94 as compared to the private sector hospital score of 92. VA facilities receiving Accreditation with Commendation (scored 90 or above with no "Type I" recommendations) were VA Hudson Valley Health Care System, New York; Mountain Home, Tennessee; Sioux Falls, South Dakota; Poplar Bluff, Missouri; Jackson, Mississippi; VA Palo Alto Health Care System, California; VA Sierra Nevada Health Care System (Reno); and West Los Angeles, California.

Conclusion

Systematic and aggressive re-engineering efforts define VHA's commitment to provide consistently reliable quality health care. We have made momentous headway in becoming an organization that routinely and methodically evaluates all aspects of our operations to identify strengths and weaknesses, one that recognizes exemplary work as well as service delivery problems, and that disperses best practices or solutions rapidly across the national system. Beginning with the Strategic Framework for Quality Management, quality considerations are built into all components of care delivery. Following the old saying that "what gets measured, gets done," VHA implemented and is tracking compliance with clinical interventions for prevention of disease and management of chronic disease, enrollment in primary care, and implementation of end-of-life planning. VHA's excellent results on JCAHO reviews and our relatively new involvement with CARF, and VA's progress in demonstrating benchmark setting achievements in each of the five domains of value, confirm our capabilities and intent to meet or exceed the same standards set for the non-VA sector.

1998 and 1999 highlights in all these areas show remarkable improvement, which, when combined with the goals for 2000 and beyond, indicate that our focus on quality is working. VHA is dedicated to maintaining and improving the consistency and predictability of high quality care, ensuring that veterans receive the best health care America has to offer.

CHAPTER 3

PATIENT SAFETY INITIATIVE

In December 1999, the Institute of Medicine (IOM) released a report entitled "To Err is Human: Building a Safer Health System." Using findings from the professional literature on hospital health care error research, the IOM report estimated that approximately 44,000 to 98,000 deaths occur in the U.S. consequent to adverse health care events. This landmark report also provided an important series of recommendations related to a range of issues including, but not limited to, event reporting, health care provider education and competency, and development of systems and methods to prevent errors. VA viewed the IOM report as validation of its dedication to continuously improving patient safety, and as a welcome opportunity to measure itself against the IOM recommendations. Of note, the IOM recommendations relevant to VA were either implemented or in the process of implementation before the release of the report.

BACKGROUND

VA is uniquely positioned to serve as a national laboratory for finding and implementing ways to prevent health care errors and improve patient safety. The veterans health care system is in the vanguard of these efforts. The system's advantages include its size and presence in every state and in almost every major metropolitan area in the Nation, its fully integrated nature, its openness to scrutiny as a public system, and its data capture mechanisms and information management infrastructure. VHA has placed great emphasis upon patient safety and ensuring safe, high-quality care. In health care, like aviation, it is imperative to investigate not only the accidents, but to understand the close calls. Close calls are more common than accidents and their analysis provides the best opportunity to learn and institute preventive strategies, as they will unmask most system weaknesses without first having to experience a tragedy. In addition, individuals involved in close calls are more willing to report and participate in the development of safety strategies and processes that will prevent similar situations from happening again.

NATIONAL PATIENT SAFETY PARTNERSHIP

VA recognizes that patient safety is not a VA-specific issue, therefore other health care organizations were asked to join an effort to understand the issues and to act for patient safety. As a result, the National Patient Safety Partnership (NPSP), a public-private consortium of organizations with a shared interest and commitment to patient safety improvement, was formed in 1997. The charter members, in addition to VA, included the American Medical Association (AMA), the American Hospital Association, the American Nurses Association, JCAHO, the Association of American Medical Colleges, the Institute for Healthcare Improvement, and the National Patient Safety Foundation at the AMA. Five additional organizations have subsequently joined the charter members: DoD - Health Affairs; National Institute for Occupational Safety and Health; Food and Drug Administration; Agency for Healthcare Quality and Research; and Health Care Financing Administration. This group addresses high impact issues that are of importance to a broad cross section of the health care industry. An example of the NPSP's activity was the establishment of a clearinghouse for information related to the effect of Y2K computer issues on medical devices. The NPSP also called public and industry attention to Preventable Adverse Drug Events and promulgated simple actions that patients, providers, purchasers, and organizations could take to minimize the occurrence of an adverse drug event. The NPSP serves as a model of what a private-public collaboration can do to improve patient safety.

Establishment of National Center for Patient Safety and Patient Safety Centers of Inquiry

VHA's National Center for Patient Safety (NCPS) was created in 1998 to take the lead in integrating patient safety efforts and innovations, and to develop and nurture a culture of safety throughout VHA. NCPS's primary goal is nationwide reduction and prevention of adverse events and close calls. Intense training for all facilities and networks in rigorous, uniform root cause and contributing factor analysis of adverse event and close call situations is planned. This will lead to actions that are effective in eliminating or correcting such situations. NCPS training will use state-of-the-art human factors and safety system approaches in patient care settings. The processes and outcomes of root cause and contributing factor analysis and resulting actions will be electronically documented, monitored, and analyzed by a patient safety information reporting system, currently under development by NCPS.

In addition, VHA established four applied research centers known as Patient Safety Centers of Inquiry (PSCIs) in 1999. The PSCIs have a collaborative reporting relationship to NCPS. These applied research centers are charged to develop practical solutions to eliminate, reduce, or prevent selected patient safety events. The primary areas of emphasis for these four centers include, but are not limited to: organization and training issues, and ongoing collaboration with the Institute for Healthcare Improvement (IHI) in the development of fast track quality and safety improvement projects at VA health care facilities (VISN 1); enhancing mobility, fall risk assessment and fall reduction, design of an optimally safe patient room for any health care setting (includes plans to develop a permanent exhibit for a local science and industry museum), and dissemination of best practice and patient safety information (VISN 8); culture change through simulation, exploration of communication glitches, and issues related to human-machine interfaces (VISN 10); and anesthesia/operating room simulation, training, and culture of safety assessment (VISN 21).

Similarly, in 1998, a workgroup of VHA Headquarters, Network, VAMC, and Employee Education System experts sponsored a collaborative series of focus groups with representatives from private and public sector consulting and health care organizations (i.e., University of Minnesota, CareGroup, Kaiser Permanente, and the National Patient Safety Foundation at the AMA). The purpose of these focus groups was to provide an opportunity to thoughtfully explore and carefully listen to the experiences, concerns, and recommendations that health care employees had about patient safety. A final report, "Patient Safety: Listening to Healthcare Employees," was developed in December 1998 by the workgroup. Many of the report's findings were similar to or supportive of overall focus group and safety culture survey findings by NCPS.

In 1995, VA instituted a **Performance Measurement System** that uses objective measures of patient outcomes to set goals and reward achievement. Beginning in 1998, VA incorporated a performance goal and measure for its executives for accomplishment in the redesign of service delivery systems directly related to patient safety. The desired overall effect of these redesigns was to enhance patient safety within each VISN. To meet the "fully successful" goal for 1999, networks were expected to redesign three major service delivery systems at all applicable facilities within the VISN. To meet the "exceptional" goal for 1999, networks were expected to redesign six major service delivery systems at all applicable facilities within the VISN. The VISN patient safety redesigns developed in 1999 addressed a broad range of health care concerns, including but not limited to patient fall risk assessment and fall prevention strategies; improvements in patient transfer processes and procedures; prevention of wrong site surgery, and; reduction and prevention of medication administration errors.

Milestones in 1997 included development of a VHA Patient Safety Event Registry, creation of the Patient Safety Improvement Oversight Committee, and publication of the initial Patient Safety Improvement Handbook. VHA is committed to advancing knowledge about patient safety and quality.

Plans for 2000 - 2005

- Patient Safety Centers of Inquiry become fully operational.
- National Implementation of Bar Coding for Medication Administration by July 2000.
  - Based on pilot experience at VAMC Topeka, it is anticipated that at least two-thirds of adverse medication events can be prevented with this system.
- National survey/assessment of safety culture.
- Full implementation of new Patient Safety Handbook.
- National training regarding: event and close call reporting, analysis, development, and implementation actions that will reduce and/or prevent recurrence of similar events and close calls.
- Development of a computerized system for reporting of mandatory event analysis and corrective actions.
- Complete development of a de-identified voluntary reporting system (PSRS).
- Bar coding blood administration at all sites and locations where blood is given.
- Development of curriculum(s) on human factors safety for targeted facility staff members and students from affiliated medical and allied health professional schools.
- Maintain feedback with facilities and networks, and improve process to ensure reporting.
- Improve analysis and correction of problems in the field.
- Summate lessons learned and best practices for VHA and other health care entities as applicable.
- Information tools that optimize usability to the field and utility for the analysts.
- Designing optimal initial and ongoing training and education (in addition, employee education related to quality and patient safety is an important component of a national performance measure).
- Expand use of simulation techniques as a training tool.
- Develop and pilot methods for systematically increasing the use of process and equipment designs that are known to reduce the likelihood for human error (e.g., simplification, checklists, forcing functions, eliminating sound-alikes and look-alikes, read-back, etc.).

1998 & 1999 Achievement Highlights

- Creation of the National Center for Patient Safety (NCPS) in 1998.
- Established and consulted an Expert Advisory Panel on Patient Safety System Design.
  - Provided recommendations to enhance the design of VA's reporting systems leading to nation-wide improvements.
  - Comprehensive, non-punitive analytic approach for close calls and actual adverse events defined. Focus on identifying vulnerabilities rather than to define rates of error.
- Inclusion of Patient Safety Redesigns in VHA Performance Measurement System.
  - Provided concrete targets and mechanisms to focus leadership efforts.
- Policy promulgated for:
  - Bar coding of blood in the operating room.
  - Bar coding patients' wristbands.
  - Removal of concentrated potassium chloride for injection from all patient units.
- VHA received the "Cheers Award" from the Institute for Safe Medication Practices (ISMP) for removing concentrated potassium chloride for injection from patient care areas throughout the VA health care system. VHA was also recognized for its efforts to create a non-punitive error-reporting program. VHA was the only health care system among the 13 recipients of the award for 1998.

1998 & 1999 Achievement Highlights (continued)

- In 1998, sponsored a collaborative series of focus groups with representatives from private and public sector consulting and health care organizations (i.e., University of Minnesota, CareGroup, Kaiser Permanente, and the National Patient Safety Foundation at the AMA) to explore experiences, concerns, and recommendations that health care employees had about patient safety.
- Patient Safety Improvement Awards Program.
  - Focuses facility-wide interest in identifying and fixing vulnerabilities in systems and processes affecting patient safety, and recognizes and rewards those innovations.
  - VAMC Topeka received the first VHA Patient Safety Improvement Award for a bar coding system that its staff developed to help reduce errors in medication administration. Plan for national implementation in 1999 and 2000.
  - 20 awards totaling more than $30,000 given.
- National Center for Patient Safety Accomplishments:
  - Designed and implemented a tailored series of questions for focus groups and developed a pilot safety culture survey, applicable to all levels of employees, in one network (results of this safety culture survey along with a system for uniformly prioritizing adverse events and close calls were presented at the November 1998 Annenberg Conference: Enhancing Patient Safety and Reducing Errors in Health Care).
  - Comprehensive revision of the Patient Safety Improvement Handbook.
  - Developed a comprehensive adverse event, close call analysis and corrective action program which includes an end-to-end handling of event reports.
  - Development and implementation of triage questions and human factors analysis tools to increase the thoroughness and quality of safety investigations.
- Establishment of four Patient Safety Centers of Inquiry in 1999.

CONCLUSION

With few successful models in large health care systems to act as a guide, VA turned to other high risk, high performance industries to learn principles for safety. VA has borrowed both methods and people from safety-conscious settings such as aviation and space travel and from underutilized disciplines like human factors engineering. These efforts have already produced significant improvements in VA.

VA is excited to be on the leading edge as health care takes a systems approach to patient safety. VA is anxious to discover new ways to make health care safer. The focus will be on prevention not punishment. Culture change is the key to this effort and that takes time.

Chapter 4

VA Special Emphasis Programs / Activities

VHA is especially focused on delivering quality health care to VA's special populations within our Special Emphasis Programs (SEPs). Typically, SEPs are clinical services that address illnesses specific to the service-connected veteran population, constitute areas of special VA expertise, or are unique programs that address the psycho-social needs of certain identified veterans. This chapter presents the 2000 goals and the 1998 and 1999 highlights for the designated 13 SEPs with a focus on improvements in quality, access, and patient functional status. Several special activities are also detailed.

VHA also has several activities that are closely monitored at any given point in time. For 1998 and 1999, the following initiatives are also detailed in this chapter: pain management, hepatitis C, high blood pressure, end of life care, and the Veterans Health Initiative.

In an effort to assure the highest quality in these program/activity areas, VHA utilizes independent external quality advisory committees for external review, oversight and participation in the SEPs. Examples of these committees include:

- Committee on Care of Severely Chronically Mentally Ill Veterans
- Geriatrics and Gerontology Advisory Committee
- Persian Gulf Expert Scientific Committee
- Advisory Committee for Prosthetics and Special Disabilities Programs
- Women Veterans Committee

The programs designated as Special Emphasis Programs are as follows:

Table 4.1

VHA Special Emphasis Programs

Addictive Disorders	Prosthetics and Sensory Aids
Blind Rehabilitation	Readjustment Counseling
Geriatrics and Long-Term Care	Seriously Mentally Ill
Gulf War Veterans	Spinal Cord Injury & Disorders
Homelessness	Traumatic Brain Injury
Post Traumatic Stress Disorder	Women Veterans
Preservation/Amputation Care	

SPECIAL EMPHASIS PROGRAMS

ADDICTIVE DISORDERS

The Addictive Disorders program provides services that improve identification, management, and treatment of addictive disorders. The program provides early intervention, stabilization (including detoxification), rehabilitative services, continuing care and monitoring services, staff education, and research. For 1999, over 20,000 individual veterans were treated in specialized substance abuse inpatient programs for a substance use disorder; approximately 11,600 veterans were provided service in extended care programs; and 132,500 veterans were provided outpatient substance abuse treatment services by specialized programs.

Plans for 2000 – 2005

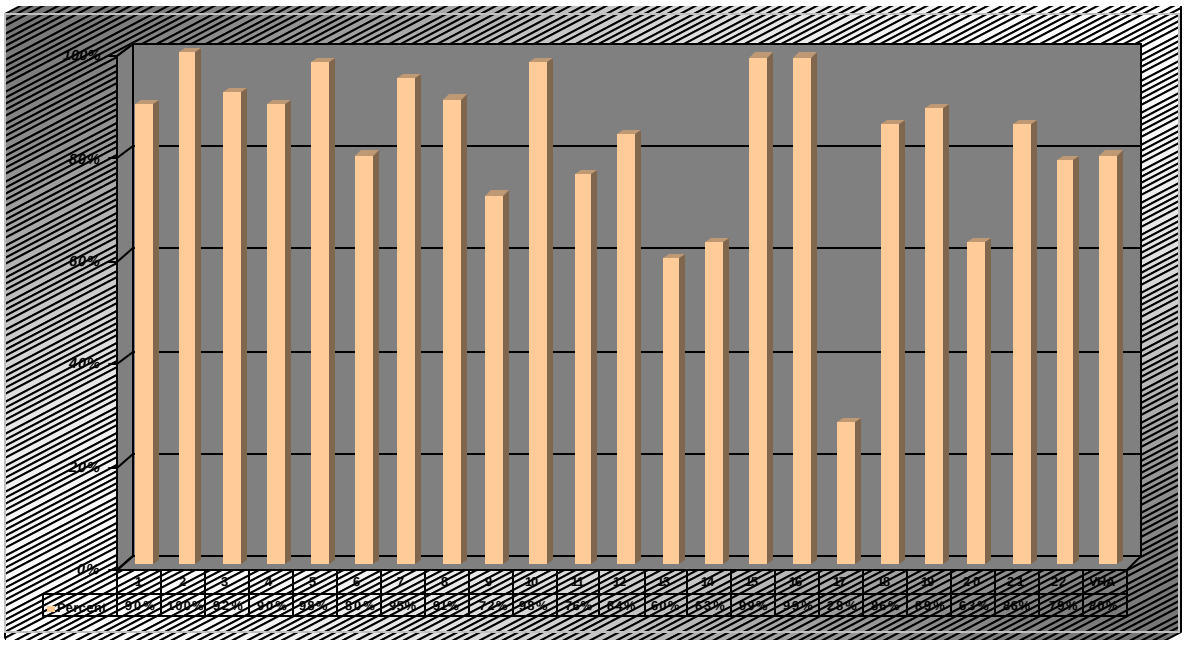
- Participate in research initiative evaluating the impact of Substance Abuse Treatment Guidelines.
- Develop joint VA-DoD treatment guidelines.
- Continue treatment outcome evaluation through Program Evaluation and Resource Center (PERC).
- Implement substance abuse treatment expansion as provided in the Millennium Health Care Act.
- Monitor utilization of Millennium resources.
- Develop additional in-service and training initiatives through the Center of Excellence in Substance Abuse Treatment and Education (CESATE) to assure that VA programs are kept up-to-date on progress being made in the addictions field.

1998 & 1999 Achievement Highlights

- Comprehensive Substance Abuse Treatment Guidelines and Algorithms were completed and submitted for Guideline Review.
- Physician training in substance abuse is provided through an initiative involving a two-year university affiliated fellowship training program offered at ten competitively selected VA Medical Centers. During the 1998 academic year:
  - Nine fellows participated in the program.
  - Two medical centers provided training in substance abuse treatment for associated health professionals at the post-doctoral and post-masters level.
- In 1998, the number of individuals treated for substance abuse (SMI only) was 100% of the 1996 level, while expenditures decreased by 29% from the 1996 level.
- In 1998, the percentage of veterans receiving any substance abuse outpatient care in the 30 days after discharge increased by 10% from the 1996 level. The number of days from discharge to the first outpatient visit decreased from 32 in 1996 to 29 in 1998.
- In 1998, 80% of substance abuse patients underwent a standardized clinical baseline assessment using the Addiction Severity Index (ASI) [Chart 4.1]. The private sector benchmark is 50%. This was not a performance indicator for 1999.
- Ninety-one percent of the eligible substance abuse patients who had a baseline Addiction Severity Index administered in September 1997, were re-assessed using the Follow-up ASI according to the 1998 Network Performance Report (Chart 4.2). This was not a performance measure in 1999.
- Developed Class III software routine to send clinical reminders to practitioners when coding substance abuse diagnoses that they need to do an ASI. (VISN 7)
- Established ASI walk-in clinics and ASI telephone interview clinics. (VISN 18)

Chart 4.1

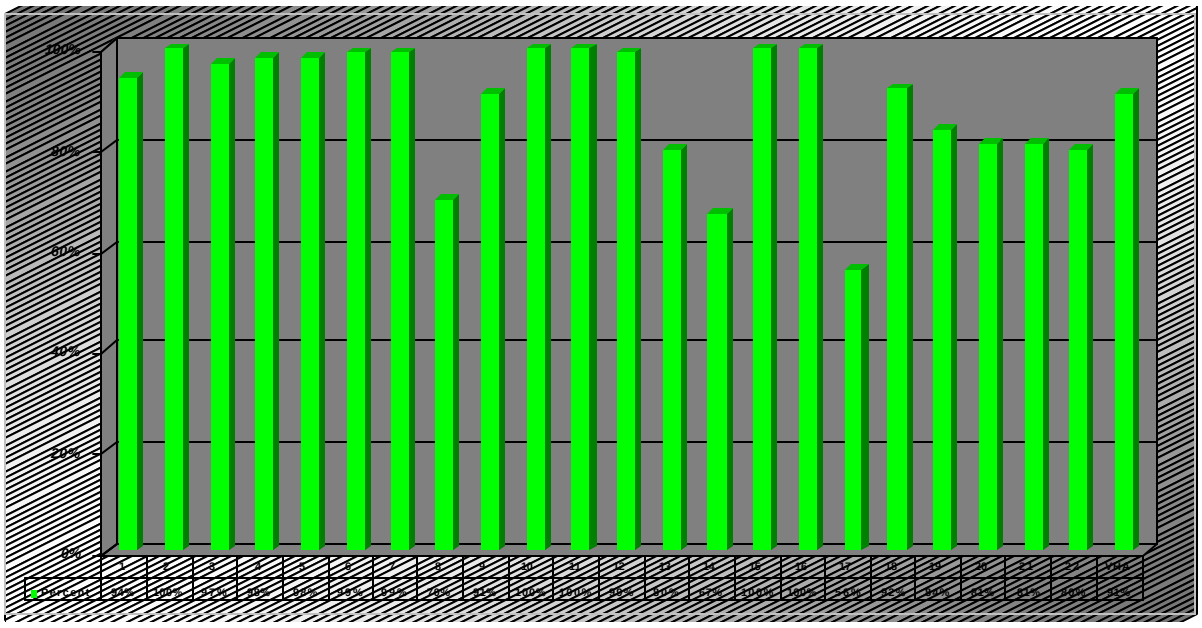
PERCENTAGE OF PATIENTS ASSESSED WITH ADDICTION SEVERITY INDEX



SOURCE: 1998 NETWORK PERFORMANCE REPORT

Chart 4.2

PERCENTAGE FOLLOW-UP ASI'S ADMINISTERED TO PATIENTS SEEN IN SEPTEMBER 1997



SOURCE: 1998 NETWORK PERFORMANCE REPORT

HOMELESSNESS

The Homeless Veterans Treatment and Assistance program identifies and seeks to ameliorate the causes and effects of homelessness among veterans. Today, VHA is the single largest direct care provider for homeless persons in the country—a critically important element in the Nation's public safety net. The program provides direct services such as outreach, case management, residential treatment, therapeutic work opportunities and assistance with permanent housing for homeless veterans and those at risk for homelessness; and coordinates the provision of care with other federal, state, and local agencies, as well as community non-profit organizations and private entities.

VA has expanded the range of services available to homeless veterans through partnerships with other federal agencies, veteran's service organizations, state and local governments and non-profit organizations.

- Since its inception in 1994, the Homeless Provider's Grant and Per Diem Program has obligated $41 million for grants for 178 projects in 42 states and the District of Columbia, which will result in 4,000 new community-based beds
- Beginning in 1999, the Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) process is being used as a method for determining the level of need of transitional housing beds for homeless veterans in each community

Plans for 2000 – 2005

- Fully integrate new homeless veterans programs into the continuum of VA's homeless veterans treatment and assistance programs.
- Expand therapeutic employment initiatives for homeless veterans.
- Initiate up to ten homeless women veteran programs.
- Initiate loan guarantee for multi-family transitional housing for homeless veterans program.
- Initiate new per diem only annual component of the grant/per diem program.
- VA medical centers will participate in at least 200 stand-downs as part of the White House Millennium Project for calendar year 2000.
- Increase the integration of homeless program planning with overall mental health systems within the networks.
- Implement project reviews based on two-year performance measurement study in the grant/per diem program.
- Increase the percentage of veterans housed after discharge from the Domiciliary Care for Homeless Veterans Program or contract residential treatment programs by .5 percentage point in 2000 and by 2.5 percentage points by 2005.
- Increase the percentage of veterans employed after discharge from the Domiciliary Care for Homeless Veterans Programs or contract residential treatment programs by 1 percentage point in 2000 and by 5 percentage points by 2005.

1998 & 1999 Achievement Highlights

- The number of homeless (SMI only) individuals treated in 1998 increased by 11% and expenditures increased by 23% from their respective 1996 levels.
- The percentage of veterans housed after discharge from the Domiciliary Care for Homeless Veterans (DCHV) program or contract residential treatment program increased by one percentage point from 1996 to 1999.
- The percentage of veterans employed after discharge from the DCHV program or contract residential treatment program increased by five percentage points from 1996 to 1999.
- Expanded "LA Vets" partnership with renovation of Cabrillo DoD housing in Long Beach for second network "LA Vets" transitional housing program. (VISN 22)
- Received HUD grant for free space in new Career Development Center in the empowerment zone in Cleveland and placed two staff there. (VISN 10)
- Conducted ten "Service Days" throughout the network that included job referrals, vocational training opportunities, and job readiness evaluations. (VISN 8)
- Appointed Network Homeless Coordinator. (VISN 2)
- Implemented the PAR (Peer Assistance Residence) program which established three veterans-only Oxford houses. (VISN 6)

Post Traumatic Stress Disorder (PTSD)

The PTSD program provides treatment for veterans suffering from PTSD syndrome including treatment to prevent relapse after reaching maximal functioning. The program serves veterans by providing supportive mental health services and by coordinating appropriate research and education projects.

VA's goal is to enhance primary care services for patients who have PTSD and other psychiatric or physical co-morbidity. It began this process through the establishment of a continuum of services ranging from specialized intensive inpatient and residential rehabilitation programs to outpatient PTSD clinical teams. Although some patients continue to require inpatient and residential care, there has been a shift to ambulatory based services. Care is provided in collaboration with VHA's 206 Readjustment Counseling Service Vet Centers.

Plans for 2000 – 2005

- Continue to increase outreach efforts to assure access to VA services who are contacted through the peer-oriented Vet Center program.
- Increase number of months of follow-up for patients with PTSD.
- Increase mental health services after the first PTSD visit.

1998 & 1999 Achievement Highlights

- The number of individuals treated for PTSD (SMI only) increased by 11% from 1996 to 1998, while expenditures decreased by 18% from the 1996 level.
- The number of individuals treated for all PTSD increased by 9% from 1996 to 1998, while expenditures decreased by 17% from the 1996 level.

1998 & 1999 Achievement Highlights (continued)

- The proportion of veterans receiving any psychiatric outpatient care within the 30 days following discharge increased by 4% in 1998 from the 1996 level. During the same interval, the time from discharge to the first outpatient visit decreased four days, from 30 to 26.
- In 1999, 56,453 veterans were seen by specialized PTSD outpatient clinics, up from 52,366 in 1998, and 51,873 in 1997.

SERIOUSLY MENTALLY ILL (SMI)

The SMI program is the largest mental health program in the country, providing state-of-the-art diagnosis and treatment to improve the mental and physical functioning of veterans in need of mental health treatment across a broad continuum of inpatient, partial hospitalization, outpatient, and community settings.

Plans for 2000 – 2005

- In the largest effort of its kind undertaken in the public sector, in 1998, VA began to collect functional status on all 600,000 veterans who annually receive specialty mental health care, using the Global Assessment of Function measurement system. Improvement in functional status will be assessed on an annual basis beginning in 2000.
- The national strategic objective is defined as evaluating every mental health patient using the Global Assessment of Functioning (GAF) scale at least once, defining those who are seriously mentally ill, and calculating the index for the SMI population. This will establish a baseline. VHA plans to raise the average GAF index 5% by the year 2003.
- Expanding state-of-the-art treatments of serious mental illness.
- Continued commitment to using state-of-the-art medications.
- Assuring ready access to crisis intervention and acute hospital care in the event of psychiatric emergency.
- Comprehensive primary physical health care to address the poor health and high risk of mortality among many people with serious mental illness.

1998 & 1999 Achievement Highlights

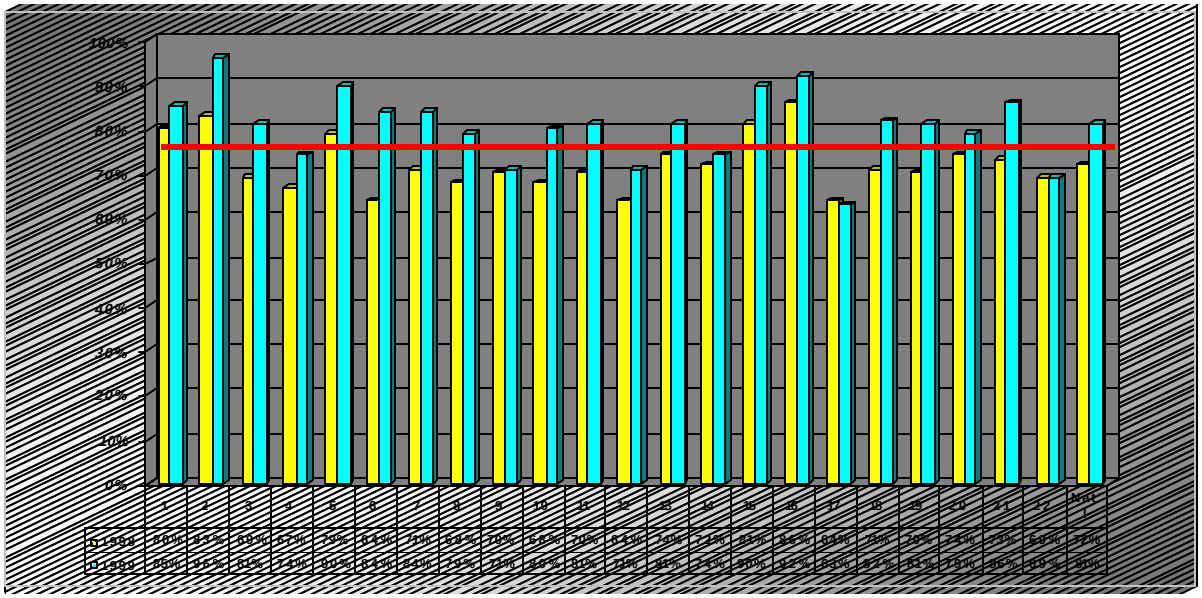
- While the number of unique inpatients treated in mental health specialty settings dropped by 11,253 (11.3%) from 1997 to 1998, the numbers of unique outpatients seen at a mental health setting increased by 45,495 (7.6%) during that same time period.
- The number of individuals treated for SMI increased by 8% from 1996 to 1998, while expenditures decreased by 9% from the 1996 level.
- The number of suicides nationally in mental health programs has dropped from 248 in 1991 to 185 in 1998, in spite of an increase in numbers of veterans served.
- VISN Behavioral Subcommittee graduated to a Health Services Council Task Force promoting a network-managed care model for mental health. Assisted hospitals in setting up case management programs for repeatedly hospitalized patients. (VISN 4)

1998 & 1999 Achievement Highlights (continued)

- A study of VA patients hospitalized with a psychosis, comparing a cohort of 86,000 patients followed up from 1988 to 1993 with a group of 77,000 veterans followed from 1994 through 1998, revealed little differences in spite of a major shift in VA policy from use of inpatient to outpatient services. About 70% of the veterans were seen for follow-up in VA settings after discharge, 10% were lost to VA care, and 20% of mostly elderly veterans had died.
- The percentage of veterans receiving any psychiatric outpatient care in the 30 days after discharge increased by 9% in 1999 (81%) from the 1998 level of 72% (see Chart 4.3). This access standard for follow-up after hospitalization for mental illness has shown a consistent and remarkable improvement since its initiation.

Chart 4.3

PERCENTAGE OF PATIENTS WITH FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (TARGET EQUALS 75%)



SOURCE: 1999 NETWORK PERFORMANCE REPORT

- Held a national suicide prevention workshop in May 1999. Distributed videotapes of the workshop across the system. (VISN 5)
- Suicide prevention activities presented to National Leadership Board in July 1999. (VISN 2, 5)

READJUSTMENT COUNSELING

Readjustment counseling is provided through a national system of 206 community-based counseling or Vet Centers. The Vet Centers are located outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. The Vet Center program service mission features a holistic mix of direct counseling and multiple community-access functions: psychological counseling for veterans exposed to war trauma to include post-traumatic stress disorder (PTSD), and/or who were sexually assaulted during military service; family counseling when needed for the veteran's readjustment; community outreach and education; and extensive case management and referral activities. The latter activities include a full range of supportive social services designed to assist veterans improve general levels of post-military social and economic functioning. Eligibility for readjustment counseling at Vet Centers includes any veteran who served in the military in a theater of combat operations during any period of war, or in any area during a period in which armed hostilities occurred. For many veterans who would not otherwise receive VA assistance, the Vet Centers are the community access points for VA health care. Vet Centers also provide care to high-risk groups such as minorities, women, the disabled, high combat exposed, rural and homeless veterans. Comprising a unique non-medical VHA program, Vet Centers report to the Chief Readjustment Counseling Officer at VA headquarters office. Locally, the Vet Centers function in full partnership with the health care facilities in each of the 22 Veterans Integrated Service Networks (VISNs) to effect a well-coordinated spectrum of care for local veterans.

Plans for 2000 – 2005

- Continue to enhance quality of care to veterans by further developing outcomes measures for client satisfaction and veteran post-treatment functional status. Starting in 2000, the complete analysis of all available Vet Center client satisfaction surveys will provide a better understanding of veteran consumer needs and responses to treatment. The introduction of quality of life measures will also add depth to the understanding of veterans' functional status following treatment.
- Enhance the Vet Center program as a VA Employer of Choice. Further development of the "Vet Centers of Excellence" initiative will provide a forum for continuous improvement to facilitate quality services and also to improve small team leadership, cooperation, and esprit de corps. The Readjustment Counseling Service will also fully participate in the Robert W. Carey Quality Award program to improve its organizational culture, program management, and service outcomes.

1998 & 1999 Achievement Highlights

- In 1998, the Vet Centers saw 131,310 total veterans and provided 804,749 visits to veterans and family members. Vet Center client activity in 1999 increased to 139,617 veterans served and 871,416 visits provided. For both years, over 50,000 of the veterans served in each year were not seen in any other VHA facility. Vet Centers make over 100,000 referrals annually to VA medical facilities, over 120,000 referrals annually to VA Regional Offices, and over 115,000 referrals annually to non-VA community service providers.
- Vet Centers maintain representative, or higher levels of minority and women veteran staffing. Vet Centers maintain 60% or higher combat theater veterans as direct service providers.
- Vet Centers track client demographics to ensure high-risk veterans are treated at levels equal to or higher than their respective levels in the local veteran population. A nationwide survey of County Veterans Service Officers conducted by VA between January and March 1998 found that 70% of the respondents used Vet Centers for assistance to homeless veterans as compared to less than 50% of respondents referring to any other VA program.

1998 & 1999 Achievement Highlights (continued)

- In 1999, 99% of veterans using Vet Centers reported being satisfied with services received by responding "yes" that they would recommend the Vet Center to other veterans. This is the highest level of veteran satisfaction recorded for any VA program.
- In 1998, the Readjustment Counseling Service initiated its "Vet Centers of Excellence" program to review criteria unique to the Vet Center mission that add value to veterans and promote esprit de corps among its teams. Five Vet Centers were selected nationwide that best represent the readjustment counseling service mission. In 1999, the Vet Centers were incorporated into VHA's process for designating clinical programs of excellence, and the Vet Centers in White River Junction, VT and Morgantown, WV were designated as VHA Clinical Programs of Excellence.
- Vet Center program clinicians collaborated with the Mental Health Strategic Healthcare Group, and other VHA mental health professionals to produce VHA's clinical guidelines on PTSD and Depression.
- The Vet Center program implemented the Vet Center-Linked Primary Care project previously authorized by the Under Secretary for Health. This initiative makes use of telemedicine technology in 20 Vet Centers to promote access to primary care for high-risk, under-served veterans closer to their respective communities. In 1998, a Vet Center outstation was opened in Martin, SD serving the Pine Ridge and Rosebud Reservations. 1999 marked the opening of a co-located Vet Center and CBOC facility in inner city Cleveland to serve African American, Hispanic and other veterans. The Vet Center outstation dedicated to serving the Cherokee in Tahlequah, OK was authorized for implementation in 1999 as well. These initiatives provide culturally sensitive services to high-risk minority veterans close to their homes.

Spinal Cord Injury and Disorders (SCI&D)

The SCI&D program assists veterans with SCI&D to develop the capacities needed to attain personal independence and life long health and well being. This is accomplished by providing acute medical/surgical care, initial rehabilitation, preventive care, lifelong sustaining care, and lifelong rehabilitation across a continuum of inpatient and outpatient settings. These health and rehabilitative services are delivered through a "hub and spokes" spinal cord injury (SCI) system of care extending from the SCI Centers to SCI Outpatient Support Clinics and SCI Primary Care Teams and non-SCI Center facilities to improve access to care. SCI care is focused around the specialized expertise of interdisciplinary care teams within the 23 regional SCI Centers. Together they serve about 15,000 veterans. Acute rehabilitation services are provided to about 400 newly injured veterans and active duty personnel annually.

Plans for 2000 – 2005

- Explore new approaches to the effects of aging with a spinal cord injury (e.g., assisted living, long-term care use, aging with disabilities, etc.).
- Database resource use to maintain current information regarding SCI&D population, processes/ systems of care, and client-centered outcomes.

1998 & 1999 Achievement Highlights

- Waiting times improved. In 1998, all SCI centers (100%) met the goals of both acute care waiting time for admission and waiting time for outpatient SCI specialty appointments. These reflect 59% and 13% improvements in timeliness of access, respectively.
- Fifty-five percent of veterans with SCI&D who responded to patient satisfaction surveys rated their SCI inpatient care as "very good" or "excellent," without change from 1997 to 1998. The scale for the survey response was poor/fair/good/very good/excellent, but only scores of "very good" and "excellent" were considered in the summary.
- Ninety-five percent of all discharges from an SCI bed section were to non-institutional, community living in 1997 and 1998.
- Conducted network-wide survey of patients enrolled in SCI Registry to determine if they were receiving annual evaluations, if they were interested in receiving annual evaluations, and if they had a preference regarding where they would receive their annual evaluations. Data were used for network planning. (VISN 7)
- Distribution and implementation of two clinical practice guidelines to 3,000 VHA health care professionals.
- Achievement of CARF accreditation by 30% of SCI Centers demonstrating quality equal to or surpassing community standards.
- Implementation of two SCI telemedicine initiatives (tele-medicine and home-care tele-consultation).
- Systematized national system for reporting program monitors and performance measures from VISNs.

TRAUMATIC BRAIN INJURY (TBI)

The TBI Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made for patients with Traumatic Brain Injury. Arrangements are made at the highest, independent living level and are confirmed through follow-up. A significant number of these patients are referred to VA facilities from the military, and lead centers have been jointly established and cooperatively funded by DoD and VA to receive and screen all TBI patients and maintain a registry of these patients nationally. The Richmond (Network 6), Tampa (Network 8), Minneapolis (Network 13), and Palo Alto (Network 21) health care facilities have been designated as lead centers for this program.

Plans for 2000 – 2005

- The TBI clinical algorithm will be implemented at all VHA TBI Network sites to ensure seamless continuity and coordination of care and link patient needs to VHA resources.
- VHA will increase the percent of first admission TBI patients discharged to a community setting (home, board and care, transitional living, or assisted living) to 69% from a baseline of 60% in 1997.

1998 & 1999 Achievement Highlights

- From 1996 to 1998, the number of individuals treated for traumatic brain injury, and dollars expended, increased by 7% and 11%, respectively.
- Waiting time between date of referral and admission into a TBI bed averaged two days and first time to TBI outpatient appointment averaged seven days. Inpatient waiting time has improved over the 1996 baseline by one day, whereas outpatient waiting time has lengthened by one day.
- Initiated ongoing collaboration with VBA for Chapter 31 benefits for eligible TBI patients to receive community rehabilitative care. (VISN 8)
- Implemented a centralized contracting service to expand options. (VISN 15)
- The number of TBI patients admitted to the Defense and Veterans Head Injury Project (DVHIP) protocol at the four lead TBI Centers increased to 174 during 1999.
- Sixty-six percent of first admission TBI patients were discharged from TBI medical rehabilitation beds to the community (home, board and care, transitional living, and assisted living residences).

GERIATRICS AND LONG-TERM CARE

Over the next 21 years, the veteran population will decline nearly 35% (assuming no major-armed conflicts). At the same time, the percent of veterans over the age of 65 will decline only by 12% while those over 85 will increase by 333%. The number of veterans over age 65 is expected to peak at 9.3 million in the year 2000, when 66% of all American males aged 65 and over will be veterans. A second but smaller peak is expected to occur in 2015, with the aging of the Vietnam War-era veterans. The general U.S. population is expected to peak in the year 2030. Of note, the number of very old veterans, i.e., those who are age 85 and over, will continue to increase until 2013. Thus, the "demographic imperative" that VHA faces will not confront the American society as a whole for another 15 to 20 years (i.e., the burgeoning population of elderly persons needing both acute and long-term health care services).

At present, 38% of the veteran population is over 65 vs. 13% of total U.S. population and over 51% of veterans who have service connected disabilities and/or who are poor are over 65 (91% of current VA enrollees have service connected disabilities and/or are poor).

Today, VA provides a comprehensive array of long-term care services that include direct VHA-provided services, services purchased in the local community, and services supported through construction and per diem grants to States. The services are offered through the following programs:

- **Home-Based Primary Care (HBPC):** Operated at 78 VA facilities to provide in-home primary medical care to home-bound veterans with chronic diseases, as well as to patients with terminal illness.
- **Geriatric Evaluation & Management (GEM) Program:** GEMs provide both primary and specialized care services to a targeted group of elderly patients.
- **Geriatric Research, Education, and Clinical Centers (GRECCs):** Centers of excellence in geriatrics; program mission is to improve the health and care of elderly veterans through research, education and training, and the development of improved clinical models of care. Plans are to expand the GRECC program based on available funds, with the goal of having at least one GRECC in each VISN.
- **State Home Construction & Per Diem Grants:** One of the longest existing Federal-State partnerships – the State Home Grant program: Department provides grants to states for the construction and support of state veterans homes.

- **VA & Community Nursing Home Care:** VA nursing homes provide skilled nursing and related medical services through an interdisciplinary approach to meeting the multiple physical, social, psychological, and spiritual needs of patients. VHA contracts with more than 3,000 community nursing homes to provide nursing home care for veterans making a transition from the hospital to the community.
- **Domiciliary Care:** In addition to services for the homeless, the domiciliary provides other specialized programs to facilitate the rehabilitation of patients who suffer from head trauma, stroke, mental illness, alcoholism, early dementia, and a number of other disabling conditions.
- **Adult Day Health Care (ADHC):** Provides health maintenance and rehabilitation services to veterans in a congregate, outpatient setting.
- **Hospice:** All medical centers have, at a minimum, an interdisciplinary hospice consultation team that is responsible for planning, developing, and arranging for the local provision of hospice care. The program offers pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families.
- **Respite Care:** This program is available at nearly all VA facilities and is designed to reduce the caregiving burden from the spouse or other caregiver by admitting the veteran to a VA hospital or nursing home for planned, brief periods, totaling no more than 30 days per year.
- **Homemaker/Home Health Aide (H/HHA):** This program enables selected patients who meet the criteria for nursing home placement to remain at home through the provision of personal care services. H/HHA services are purchased by VHA from public and private agencies in the community.
- **Alzheimer's & Dementia Initiatives:** Approximately 55 medical centers have developed specialized programs for the care of veterans with dementia which include:
  - Inpatient and outpatient dementia diagnostic programs.
  - Behavior management programs.
  - Adapted work therapy programs for patients with early to mid-stage dementia.
  - Alzheimer's special care units within VA nursing homes and transitional care units.
  - A model inpatient palliative care program for patients with late stage dementia.
- **Community Residential Care/Assisted Living:** This program provides room, board, personal care, and general health supervision for veterans who, because of health conditions, are not able to live independently and have no suitable family or social support system to provide needed care.

In November 1996, a federal advisory committee was chartered to provide advice and recommendations on VA's current and anticipated needs for long-term care. The Federal Advisory Committee's Report, *VA Long-Term Care at the Crossroads,* concluded that long-term care must remain an integral part of the veterans health care system. VHA concurs with this recommendation. The Committee's report was widely reviewed and commented on by VHA stakeholders.

Plans for 2000 – 2005

- VA has drafted a plan for implementation of the Committee's recommendations which include plans to increase the percentage of long-term care patients who are cared for in clinically appropriate community settings to 29% in 2000 (from a baseline of 12,976 patients in 1997).

1998 & 1999 Achievement Highlights

- 134 nursing homes provided care for over 13,000 veterans on any given day.
- 41 states were given grants for 92 nursing homes caring for almost 15,000 veterans daily.
- Contracts were maintained with more than 3,000 private nursing homes for the care of 5,600 veterans per day.
- Domiciliary care at 40 sites provided for the care of 5,600 veterans daily.
- 32 states were provided with grants for 46 facilities treating 3,600 veterans each day.
- Health and safety of 87,900 veterans in community residential settings was overseen.
- In home and community-based care, VA operated 78 specialized home health care programs for the chronically ill and homebound. VA treated 6,300 veterans daily.
- Professional and homemaker services were purchased for 4,200 veterans each day.
- Provided and purchased adult day health services for 1,000 veterans daily.
- Currently, 110 VA medical centers have GEM programs that include inpatient units and/or outpatient clinics, as well as consultation services.
- Currently, 18 GRECCs exist throughout the VA system, each with a distinct programmatic focus.
- 75 VA facilities offer inpatient hospice care as well as consultative services.
- VA's *Alzheimer's Caregiving Strategies*, a multi-media computer program (CD-ROM), was distributed to all VA facilities for education and training of family caregivers for persons with dementia.
- A new VA clinical guideline, *The Pharmacologic Management of Cognitive Changes in Alzheimer's Disease*, was completed.
- The Minneapolis VA GRECC produced a four-part satellite videoconference series on the diagnosis and treatment of Alzheimer's disease.
- The implementation phase began for "Chronic Care Networks for Alzheimer's Disease," a national demonstration project on Alzheimer's disease and managed care, co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium, with VA participation through its Upstate New York Health Care Network. (VISN 2)
- Expanded geriatric clinic activities throughout the network to provide standardized patient care and health education services to geriatric patient population. (VISN 17)

GULF WAR VETERANS

The Gulf War Veterans program provided strategic direction for the clinical, research, education and outreach programs for these veterans and ensures that available benefits are provided to eligible claimants. This is accomplished by working collaboratively with other VA offices; federal, state, and local government agencies; and, non-profit community and private providers. The Gulf War Veterans program staff also serve as VHA's liaison to the Military Veterans Coordinating Board, an interagency organization co-chaired by the Secretaries of Veterans Affairs, Defense, and Health and Human Services. The ultimate goal is to ensure appropriate, quality health care for Gulf War Veterans.

Plans for 2000 – 2005

- The Department's Environmental Agents Service (EAS) will place the highest priority on expanding its comprehensive risk communication program for Gulf War veterans, as well as for veterans from other periods. To effectively get the message out to veterans and their families, this program will take maximum advantage of web-site and other media, as appropriate.
- The "VA National Health Survey of Gulf Veterans and Their Families," the government's most comprehensive population-based study on the health of Gulf War veterans, will be extended to find out how the health of these veterans changes over time. Capitalizing and expanding upon efforts in the current study is the best and fastest way to measure how changes to the health of Gulf War veterans over time compares to that of other veterans.
- Continued and productive collaboration with the Departments of Defense and Health and Human Services on a wide range of health care and research focusing on veterans' health. The focus of this collaboration will be the new interagency Military and Veterans Health Coordinating Board.
- A report from the National Academy of Sciences Institute of Medicine that evaluates the scientific and medical literature relating Gulf War hazards to specific illnesses is due in 2000 and will provide a basis for determining which illnesses suffered by Gulf War veterans should be presumed to be related to Gulf War service. The Department will request IOM to perform additional studies on this critical issue.

1998 & 1999 Achievement Highlights

- The Department's Environmental Agents Service responded to the special report of the Presidential Advisory Committee (PAC) on Gulf War Veterans' Illnesses. The EAS response to the PAC's recommendations was coordinated with the Departments of Defense and Health and Human Services, and included the submission of a comprehensive health risk communication plan for Gulf War Veterans.
- VHA published the first continuing medical education self-study program for VA physicians on Gulf War Veterans' issues. Entitled, *A Guide to Gulf War Veterans' Health, 1998 Continuing Medical Education Program Independent Study*, it was a collaboration of the Office of Public Health & Environmental Hazards and the Office of Employee Education.
- VHA initiated policies and procedures for evaluating Gulf War Veterans with possible exposure to depleted uranium (DU). This new protocol is part of a joint VA/DoD medical follow-up program designed to identify veterans with higher than normal levels of uranium in their urine, and allow scientific documentation of the presence or absence of medical effects from DU exposures.

1998 & 1999 Achievement Highlights (continued)

- The *VA National Health Survey of Gulf Veterans and Their Families*, the government's largest study of the health of Gulf War Veterans, moved from surveys and record reviews to physical examinations and clinical testing. Participating veterans will be examined at one of the 16 VA medical centers around the country.
- VA started a $20 million effort with DoD to begin two large-scale randomized, controlled treatment trials for the symptoms of undiagnosed illnesses of Gulf War veterans. VA's Cooperative Studies Evaluation Committee and an advisory panel of independent scientific experts approved the Exercise/Behavioral Therapy (EBT) Trial and the Antibiotic Treatment (ABT) Trial. The EBT and ABT trials are research studies and not part of standard clinical care for Gulf War Veterans.
- The President announced the creation of a Military and Veterans Health Coordinating Board to improve collaboration between VA, DoD, and the Department of Health and Human Services (HHS) on a wide range of health care and research issues relating to Force Health Protection and past, present, and future service in the Armed Forces.
- VA expanded its program to reach out and educate Gulf War veterans about the benefits and services available to them and the research initiatives undertaken on their behalf. A number of publications and projects were revised and updated, and several new initiatives were announced. These efforts have increased the number of Gulf War veterans who have completed the Registry examination to more than 75,000.
- VA continued to take the lead in coordinating federal research related to Gulf War veterans' illnesses. This commitment has now reached $133 million cumulatively in support of 145 federally sponsored research projects.

WOMEN VETERANS

VHA Women Veterans Health Program ensures the integration of clinical care, education, outreach and research to improve the utilization of VHA health care programs by women veterans. Eight national designated Women Veterans Comprehensive Health Centers as well as local VHA facilities provide primary care and gender-specific health care services to women veterans with a focus on quality, sensitivity and customer satisfaction.

Plans for 2000 – 2005

- Improve women veterans' satisfaction with care and service.
- Aggressive outreach and treatment of sexual trauma.
- Develop programs and services for homeless women veterans and women veterans with children.
- Target women veterans for disease prevention and health promotion activities.
- Provide quality gender-specific health care services and products.
- Increase women veterans' enrollment.
- Focus on continuing education for Women Veterans Coordinators and other health care providers.
- Improve women veterans' health data capture processes.
- Advancement of women veterans' health care research initiative/studies.
- Encourage medical centers to strive to achieve Clinical Centers of Excellence in Women's Health designation.

1998 & 1999 Achievement Highlights

Clinical Services

- Over 142,000 women veterans utilized VHA services in 1999. Preventive health services provided in 1998 included 55,928 Pap smears and 40,722 mammograms which represent a 6 and 12% increase, respectively, from 1997.
- Reproductive health services were expanded to include the provision of maternity and infertility benefits.
- Sexual trauma counseling was provided to 5,868 women veterans in either VA facilities or through contractual agreements in 1998.

Program Advancements

- The Women's Health software and the beginning implementation of the Military Sexual Trauma software established standardization of data collection and monitoring of services provided system-wide to women veterans.
- Three Clinical Centers of Excellence in Women's Health (Durham, Alexandria, and Pittsburgh) were selected to serve as "best practice" models of care in VHA.

Education

- Educational initiatives in 1999 included mini-residencies (i.e., breast care, Women Veterans Coordinator training, colposcopy, mental health, sexual trauma, women's health software, gender-specific care for providers), clinical updates for primary care providers in women's health, a national Women Veterans Coordinators Conference and other local and VISN-level conferences on women's health.

BLIND REHABILITATION

The Blind Rehabilitation Service provides services to eligible veterans who meet the definition of legal blindness (a person's best corrected visual acuity in the better eye is less than or equal to 20/200, or if the central visual acuity in that eye is better than 20/200, the visual field is less than or equal to 20 degrees in the widest diameter). The Service is dedicated to improving the quality of life for blinded veterans by assisting them to develop the skills and capabilities needed to attain personal independence and emotional stability. The Service accomplishes this goal through identification of visually impaired veterans, provision of comprehensive inpatient and outpatient rehabilitation services, education of blinded veterans and their families, and on-going research. Research is conducted by research personnel at three of the Blind Rehabilitation Centers. Research is also conducted by the Rehabilitation Research and Development Center at VAMC Decatur.

Plans for 2000 – 2005

- Establishment of 15 bed Blind Rehabilitation Center at VAMC West Palm Beach.
- Establishment of additional Blind Rehabilitation Outpatient Specialist (BROS) positions.
- Development of clinical algorithms to provide for the most appropriate rehabilitation training model for visually impaired veterans based upon the individual veteran's general functioning level.

Plans for 2000 – 2005 (continued)

- Development of competencies for Visual Impairment Services Team (VIST) Coordinators and BROS.
- Continue with research projects (post grant funding) to develop functional scores in skill areas to be used in development of screening tools and clinical algorithms.

1998 & 1999 Achievement Highlights

- The number of individuals treated for blindness and dollars expended each increased by 23% from 1996 to 1998.
- Of the nine Blind Rehabilitation programs, five VISNs exhibited an improvement in waiting time for admission to each of the inpatient blind rehabilitation programs from 1996 to 1998.
- The Blind Rehabilitation program celebrated its 50th anniversary in July 1998.
- For 1997, 1998, and 1999, the program has consistently maintained a rate of 98% of the blinded veterans responding to a Blind Rehabilitation Customer Satisfaction Survey who said that they were either "Satisfied" or "Completely Satisfied' with the inpatient Blind Rehabilitation Center program.
- Increased the number of blinded veterans who received inpatient rehabilitation training at the Blind Rehabilitation Centers from 1,634 in 1997 to 1,760 in 1999.
- Increased the number of blinded veterans served by the BROS from 873 in 1997 to 1,713 in 1999.

PRESERVATION/AMPUTATION CARE AND TREATMENT (PACT)

The PACT program is focused on reducing the incidence of amputations and other complications due to diabetic foot ulcers and peripheral vascular disease. An interdisciplinary program of care and treatment is provided to patients. Patients with amputations and those identified as at risk for limb loss are tracked and monitored.

Plans for 2000 – 2005

- VHA will evaluate the PACT program for effectiveness and efficiency in returning amputee patients to their highest level of function in a community setting.
- VHA will increase the percentage of diabetic patients identified as at-risk for limb loss who are referred to a foot care specialist to a total of 88% for 2000. This is a targeted increase of 2% over 1999's target of 86%.

1998 & 1999 Achievement Highlights

- The number of individuals treated for amputation in 1998 was 95% of the 1996 level, while expenditures decreased by 11% from the 1996 level.
- Seventy-seven percent of lower extremity amputee patients were discharged from inpatient rehabilitation units to a community setting (home, board and care, transitional living, and assisted living residences).

1998 & 1999 Achievement Highlights (continued)

- During 1999, 86% of diabetic patients identified as "at-risk" for amputation were referred to foot care specialists for further screening and evaluation. This represents a 5% increase over the 4th quarter of 1998, when the measure was instituted.
- The development of a technology based CD-ROM, "Preservation-Amputation Care and Treatment Courseware," was begun in the 3rd Quarter, 1999, and is expected to be released during the 2nd Quarter, 2000. The courseware is directed toward Primary Care providers and PACT team members and focuses upon early detection and prevention of foot care problems in the diabetic population.
- During the first 11 months of 1999, 18 facilities collected outcomes on all patients undergoing a new lower extremity amputation and entered the data into the Functional Status and Outcomes Database (FSOD) for Rehabilitation. The Physical Medicine and Rehabilitation Program Office is using the data to establish VA mean average outcomes scores for the amputation population across the continuum of care.

Prosthetics and Sensory Aids

The Prosthetics and Sensory Aids Service Strategic Healthcare Group (PSAS) furnishes prescribed prosthetic equipment, sensory aids and devices to eligible disabled veterans in the most economical and timely manner in accordance with authorizing laws, regulations, and policies. PSAS also serves as case manager for the physically disabled veteran to provide quality prosthetic and sensory aids services. The objectives of the Service are to restore the capability of disabled veterans to the greatest extent possible, improve their quality of life, and to continually assess veterans' satisfaction with VA-prescribed prosthetic and sensory aids.

Plans for 2000 – 2005

- Prosthetic/Orthotic Laboratory Software Module redesign.
- Design clothing allowance and automobile adaptive equipment software to be incorporated into the Prosthetic Software Package.
- Implement recommendations from the Booz-Allen and Hamilton report, "Improving the Efficiency and Effectiveness of Providing Prosthetic and Sensory Aids Services within VHA." These recommendations focus on defining PSAS's identity to improve performance through defining the mission, goals, objectives, and management strategies; designing a structure that ensures consistent policy implementation, efficient service delivery, and appropriate coordination of care; and, integrating quality improvement activities with a formal communications plan to promote ongoing effectiveness.

1998 & 1999 Achievement Highlights

- Received Scissors Award for developing and implementing a national data and information system known as the National Prosthetic Patient Database (NPPD). NPPD contains all data on the Prosthetic Patient's Record (VAF 10-2319) at each VA facility and is based on the Health Care Financing Administration's Common Procedures Coding System that provides a standard national nomenclature to ensure consistent reporting for comparative evaluation purposes.

1998 & 1999 Achievement Highlights (continued)

- Solicitation templates for local orthotics' contracts and eyeglasses contracts were provided to all VISNs so that they could have the benefit of locally managing the contracts as well as realize discounts and savings through the use of competitive procurement, market leveraging, and preferred provider status.
- Developed and implemented network-wide prosthetic program and policies. (VISN 1, 2, 6, 10)
- Instituted standardized ordering system to enhance compliance with guidelines. (VISN 9)
- 11% increase in veterans served in 1999 from 1998.
- Conducted cost analyses for scooters, TENS units, and TLSO's and provided information to the VISN Prosthetic Representatives.
- Mandated the implementation of the Prosthetic Inventory Package which established a valid prosthetic data inventory system utilizing standard nomenclature in all recording activities.
- In September of 1998, the Under Secretary for Health charged the Chief Consultant of the Prosthetic and Sensory Aids Service SHG to establish a plan and workgroup to improve the operations of the prosthetic program in Headquarters and the field. This initiative was the *Prosthetic Program Reinvention Program (PPRP)*. Specific actions that were implemented include:
  - Performance measures for the Prosthetic and Sensory Aids Service were included in the 1999 Network Directors Performance Agreement:
    - Designation of a single VISN Prosthetic and Sensory Aids Service Representative (VPR).
    - Implementation of a VISN-wide budget for PSAS.
    - Conducted VISN forums for stakeholder input to better formulate relevant VISN-wide prosthetic policies.
  - The National Performance Data Feedback Center in Durham, North Carolina, produced a quality survey instrument to sample recipients of prosthetic items. In 1999, approximately 23,000 surveys were mailed to veteran users of eyeglasses, hearing aids, blind aids, wheelchairs, and artificial limbs.
  - A PSAS field staffing and workload survey was completed and a final report prepared. The final report provides the opportunity to analyze and compare workload, staffing levels, organization structures and program complexities at each site in order to address program operations and best practices in sites and VISN's as they relate to the operation of a successful prosthetic program.
  - Instituted quarterly reviews of the NPPD by the Prosthetic Data Validation Workgroup to ensure high quality data.

SPECIAL ACTIVITIES

PAIN MANAGEMENT STRATEGY

VHA recognizes that pain is a serious problem in the U.S. The knowledge and techniques to control most pain are known, but they are often not applied effectively. VHA is taking a comprehensive, systematic approach to improve the care of patients with pain. The goal is that no patient cared for in VHA health care system shall suffer from preventable pain. The purpose of the VHA National Pain Management Strategy is to develop a system-wide approach to pain management that will reduce pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses, including terminal illness. Specific objectives are to:

- Assure that pain assessment is performed in a consistent manner
- Assure that pain treatment is prompt and appropriate
- Include patients and families as active participants in pain management
- Provide for continual monitoring and improvement in outcomes of pain treatment
- Provide for an interdisciplinary approach to pain management that includes a wide range of pain management modalities (e.g., medications, physical therapy, biofeedback, services of pain management specialists, and psychosocial support)
- Assure that doctors, nurses and other members of the health care team practicing in all VHA settings are adequately prepared to assess and manage pain effectively

Key Elements of VHA's Pain Management Strategy

Pain Assessment and Treatment. Procedures for early recognition of pain and prompt effective treatment are being implemented by all VA medical treatment facilities.

- "Pain as the 5th vital sign" is being implemented in all clinical settings
- Pain management protocols are being established and implemented in all clinical settings
- Systems will be put in place to increase access to resources such as pain specialists and multidisciplinary pain clinics and centers
- Patient and family education about pain and its management will be included in patient treatment plans

Evaluation of Outcomes and Quality of Pain Management. VHA is implementing processes for measuring outcomes and quality of pain management, including patient satisfaction. The goal is continual quality improvement.

Research. VHA will expand its research on management of acute and chronic pain, emphasizing conditions that are most prevalent among veterans.

Education of Health Care Professionals. VHA is working with its Employee Education System to ensure that employees throughout the VHA health care system have appropriate orientation and education related to pain assessment and pain management. VHA standards for pain management will be communicated to all medical students, allied health professional students, residents and interns providing patient care in VHA facilities.

Plans for 2000 – 2005

- Develop and implement performance measures.
- Develop a "traveling road show" with core topics and materials that can be easily customized to meet the needs of the local facility, VISN, or special interest group with content appropriate for the target population.
- Conduct a series of three accredited pharmacy satellite education programs supplemented with print materials.
- Develop web-based education for pain management topics.
- Develop pocket-grids for pain assessment, intervention, and follow-up for clinicians.
- Develop and implement a minimum of two internship or traineeship type programs.
- Develop pain management networks and strategies within VISNs to assist non-pain specialists based at remote sites such as Community Based Outpatient Clinics (CBOC), Outpatient Clinics (OPC), and HBPC programs.
- Develop methods and models for pain management data entry with clinical reminders to ensure that pain is managed appropriately and consistently system-wide.
- Implement methodology throughout the system for electronic pain management data collection to provide outcomes information for continuous improvement and to meet JCAHO standards.

1998 & 1999 Achievement Highlights

- A National End of Life and Pain Management Conference for education, problem solving and showcasing innovations was held with over 300 attendees. Proceedings of the conference will be published in *VHSJ* for continuing medical education (CME) credit. VA Pain Management and End of Life online "conference" is active at http://www.growthhouse.org.
- The Margo McCaffery Pain Management Video Library was purchased and placed in each VISN library.
- A Collaborative to create rapid improvement in Pain Management has been initiated with the Institute for Healthcare Improvement.
- Implementation of Pain Management Outcomes measures is in process.
- Improvements in the electronic documentation for Pain Assessment have been made.
- Creation and dissemination of a Pain Management Toolkit.

HEPATITIS C

Hepatitis C Virus (HCV) is a serious national problem that has reached epidemic proportions. Nearly four million or 1.8 percent of Americans are believed to be infected with HCV. Hepatitis C has particular importance for the Department of Veterans Affairs because the prevalence in VA's service population is substantially higher than in the general population. The Acute Care Strategic Healthcare Group has been given responsibility for the planning and oversight of initiatives within VHA for the management of Hepatitis C system-wide.

Plans for 2000 – 2005

- Make the National Institutes of Health and VA Clinical Grand Rounds on Hepatitis C available at all VA facilities via teleconference.
- Distribute copies of the CME program based on the September teleconference.
- Analyze and report findings from the survey, conducted at the request of the House Veterans Affairs Committee, involving all facilities to assess the screening and treatment programs within medical centers and associated Community Based Clinics.
- Publication by The Federal Practitioner of three articles on HCV authored by VA physicians and provision of continuing medical educational credits to physicians.
- Implementation of a multicenter cooperative study with the major objectives being to: establish treatment response to standard therapy with interferon/ribavirin; determine the proportion of veterans with HCV disease who are suitable candidates for treatment; evaluate the epidemiology of HCV genotype distribution in relation to key risk factor variables; determine the clinical, demographic and epidemiologic variables associated with hepatic fibrosis score in HCV disease in treatment candidates; comparatively evaluate the response rates to standard therapy in different ethnic groups within the study population; evaluate the safety and tolerability of standard therapeutic regimens of interferon/ribavirin in the veteran population.
- Develop and disseminate patient/family education material in various formats, including brochures and videos.
- Develop and implement an automated Hepatitis C Patient Clinical Reminder to improve the screening and treatment process.
- Continue to educate VA personnel on Hepatitis C using different educational modalities (conferences, website, videotapes, etc.).
- Partner as appropriate with other Federal agencies for management of Hepatitis C.

1998 & 1999 Achievement Highlights

- March 1998: the Committee on Government Reform and Oversight, Subcommittee on Human Resources held hearings regarding a VA response to HCV.
- June 1998: the Under Secretary for Health distributed an Information Letter which outlined VA's approach to risk stratification for HCV and set into motion a plan of action to combat the disease.
- September 1998: a VA task force was convened with the charge of developing the VA strategic plan to address the special challenges of the HCV epidemic.
- November 1998: VA's Emerging Pathogens Index (EPI) registry was fully integrated to include HCV.
- January 1999: VA accomplished an internal rollout of its HCV Strategic Initiative at a quality forum in conjunction with the National Leadership Conference. The Under Secretary for Health held a briefing to outline VA's five-point strategy.

1998 & 1999 Achievement Highlights (continued)

- To address needs of HCV-positive veterans, VA designated medical centers in Miami, FL and San Francisco, CA as Centers of Excellence to serve as research and education lynchpins of the VA 5-point strategic initiative to respond to HCV. The 5-point strategic initiative includes: (1) patient education; (2) health care provider education; (3) epidemiologic assessment; (4) treatment; and (5) research.
- February 1999: VA's treatment guidelines and clinical protocols for patients with HCV were completed and distributed.
- March 1999: VA conducted a nationwide surveillance activity and tested over 26,000 veterans for HCV on a single day. The data collected from this sample will be utilized to assess risk factors, prevalence rates, and serve as a basis for VA's ongoing HCV planning.
- April 1999: VA received a special award from the American Liver Foundation (ALF) in recognition of its leadership and extraordinary work in advancing the identification and treatment of patients with liver disease, especially HCV.
- June 1999: VA hosted a National Symposium in Washington, DC to augment the education of VA clinicians about the appropriate diagnosis and treatment of patients with HCV.
- July 1999: Online activation of VA's HCV informational website.
- September 1999: VA held a nationwide teleconference that was broadcast to all VA medical centers with distribution of videotapes to the Veterans Service Organizations for additional outreach purposes.

Hypertension Care Improvement Initiative

VHA has been a leader in the management of hypertension since the 1960s, having sponsored the first cooperative trial that definitively demonstrated that treatment of moderate to severe hypertension reduced later morbid events and mortality. VHA has continued to demonstrate the value and contribution of a strong collaboration between research and clinical care to improve quality outcomes. A recently published VA research study has produced a novel approach for assessing hypertension care and suggests that more aggressive hypertension management can produce better outcomes. Therefore, VHA is now reinvigorating its activity related to hypertension.

The purpose of the VHA National Hypertension Care Improvement Initiative is threefold: (1) to reemphasize the importance of treatment and control of hypertension, (2) to highlight benchmark approaches and breakthrough behavior for control of hypertension, and (3) to define a system-wide standard of care, strategies to achieve this standard, and identification of barriers to accomplish these strategies. The objective of this initiative is to better control hypertension in the veteran population VHA serves and to reaffirm VHA's position as a leader in clinical care, education, and research in hypertension. Some activities must be completed in order to define further objectives such as those related to diagnosis and clinical management of hypertension. The specific, initial objectives were to:

- Convene an invitational conference that will bring together the major organizations that have special interest in the state of the science and quality of care for management of hypertension
- Provide a system-wide VHA standard of care for the diagnosis and treatment of hypertension
- Assure that knowledge of the standard of care is widely known and applied within the VA health care system
- Conduct outcomes research to evaluate quality of care for patients with hypertension

Plans for 2000 – 2005

- Proceedings of the invitational conference will be published and widely disseminated within and outside the VA system to assure that practitioners and managers are aware of the outcomes and recommendations.
- Develop a specific plan for translating the knowledge gained into practice behaviors – develop a CME course for appropriate clinical staff regarding clinician competence and expertise in hypertension prevention, diagnosis, and management.
- A VA task group has been convened to use the outcomes of the conference to define clinical guidelines and performance measures for use in VA.
- VHA will continue to evaluate drug therapies as the number and classes of available anti-hypertensive medications continue to expand.
- Conduct long-term clinical trials to determine if treatment with newer agents also contributes to a decrease in morbidity and mortality.
- Office of Research and Development will (1) adapt measures of intensity of anti-hypertensive therapy and blood pressure control for use with current VHA data bases, (2) examine physician performance using recently developed process and outcomes measures, and (3) develop methods for providing feedback to physicians (and other practitioners) on their performance in hypertension care.
- Remeasurement of system improvement in the care of hypertension and its relationship with overall quality of care changes after full implementation of the standard of care and the clinical practice guidelines.

1998 & 1999 Achievement Highlights

- Invitational Conference held on May 26, 1999. VHA convened an international consensus conference that brought together representatives of government and non-government health care and health care related organizations to debate the current state of the science related to the prevention, diagnosis, and management of hypertension.
  - Representatives were drawn from across the range of health care disciplines with special interest in hypertension and included direct care practitioners, educators, economists, researchers, and payors.
  - Organizations represented included the Department of Defense – Health Affairs; National Heart, Lung, and Blood Institute; Agency for Health Care Policy and Research; Public Health Service; Health Care Finance Administration; Kaiser Permanente; Allina; Harvard Pilgrim; United Healthcare; Institute of Medicine; American College of Physicians; and Institute for Healthcare Improvement.
  - Issues the conferees addressed included prevention, clinical trials over the past 30 years, present status of hypertension in the U.S. and elsewhere in the world, goals of care, and management approaches. These topics probed effects of lifestyle, incidence in specific geographic locations and within specific populations, costs of care and treatment protocols that include a focus on the elderly, patients with diabetes, etc.
- A VA task group was convened to use the outcomes of the conference to define an appropriate standard of care, clinical guidelines, and performance measures for use in VA. The standard of care was disseminated in August/September 1999.

1998 & 1999 Achievement Highlights (continued)

- As appropriate, the hypertension practice measure currently in place was revised.
- Added to the Chronic Disease Care Index a measure of blood pressure control in patients diagnosed with hypertension. It is being routinely monitored. This is in addition to elements related to exercise counseling and nutrition counseling that have been monitored since 1996.

Initiative to Improve Care at the End of Life

VHA recognizes that there is much that can be done to relieve suffering, respect personal dignity and improve the care of dying veterans. There are several factors that make it important for VHA to focus on this crucial issue at this time:

- Serious, life-limiting illnesses are prevalent in the aging veteran population
- VHA is the Nation's largest integrated health care system
- VHA has decades of experience in geriatric and palliative care
- VHA's academic and educational affiliations provide an opportunity to influence the education of large numbers of physicians, nurses, and other health care professionals in the area of end of life care
- VHA's research capacity provides an opportunity to strengthen the knowledge base in end of life care

In 1997, VHA initiated a national strategic effort to improve care at the end of life. The recommendations of the Institute of Medicine's published report, "Approaching Death: Improving Care at the End of Life" (1997) serve as a framework for this initiative. The specific elements of VHA's strategic initiative include:

- Identifying and disseminating state-of-the-art practices in care of the dying
- Improving systems and organizational processes to achieve reliable, excellent care for patients during the last phase of life
- Strengthening methods for measuring processes and outcomes of care for dying patients and their families
- Designing education for VA health professionals and affiliated trainees to assure that caregivers have the knowledge, skills and attitudes to care well for dying patients and their caregivers
- Empowering patients and their families through education about end of life care
- Collecting data on quality, access, cost and utilization to inform public policy
- Collaborating with other national organizations and with health care providers that are similarly committed to improving the care of patients during the last phase of life

In 1997, a VHA system-wide performance measure for palliative care, the Palliative Care Index, was initiated. National performance has improved from 67% in 1997 to 94% in 1999. (A graph is displayed in Chapter 2, *VA Health Care Quality Management*)

Plans for 2000 – 2005

- The CARED Project (Caregiver Assessment Regarding End-of-Life in Dementia) is studying the current status of end-of-life care for patients with dementia and developing recommendations for an innovative home and community-based service model. This project received support from the Alzheimer's Association.
- Continue to monitor the Palliative Care Index progress.

1998 & 1999 Achievement Highlights

- In May 1998, VHA held the first national summit to develop a comprehensive, system-wide VA strategy to improve care of veterans at the end of life. Three strategic goals were identified:
  - No dying veteran shall suffer preventable pain while being cared for by the VA health care system.
  - Every veteran with a serious, life-limiting illness receiving care from VA shall have an individualized plan for comprehensive, coordinated, palliative care services that minimizes physical, psychological, social and spiritual suffering and optimizes the patient's quality of life.
  - Every veteran enrolled in the VA health care system who has a serious, life-limiting illness shall have access to hospice care and/or palliative care services and shall have an understanding about the availability of those services.
- The VA Faculty Leadership Project for Improved Care at the End of Life was initiated in 1998. Faculty leaders at 30 VA-affiliated internal medicine training programs across the country are participating in a two-year project to develop and implement curricula for state-of-the-art care for patients through the end of life. This project received funding support from the Robert Wood Johnson Foundation.
- The VA Hospice Study was completed in 1998 and sent to Congress with recommendations in response to the Study's findings from the Secretary of Veterans Affairs. The study, along with the recommendations, was distributed to VA medical centers and hospice programs.
- VHA co-sponsored a nine-month collaborative effort with the Institute for Healthcare Improvement and the Center to Improve Care of the Dying (CICD) on Improving Care for Patients Approaching the End of Life with COPD and CHF. Seventeen VA sites participated in this collaboration and a number of them achieved breakthrough improvements. Results of the collaboration were presented at a national conference in Atlanta in September 1999.
- A National Pain Management and End of Life Care Leadership Conference was held in November 1999 with more than 300 attendees. The conference showcased a number of innovations which have been implemented as a result of the 1998 National Strategy Summit.
- A web site has been developed as part of the Faculty Leaders Project and has become a valuable resource on end of life care for physicians and other health care professionals both within and outside the VA. The web site for the VA Faculty Leaders Project is http://www.va.gov.oaa/flp.

VETERANS HEALTH INITIATIVE

The Veterans Health Initiative was established by the Acting Under Secretary for Health in September 1999 to recognize the connection between certain health effects and military service, prepare health care providers to better serve veteran patients, and to provide a data base for further study. The development for this initiative began with the Military Service History project which involved a pocket card for medical residents detailing the important components of a military service history targeting the health risks associated with various periods of service, more generic issues of concern, and a web site containing references relevant to the issues.

The components of the initiative will be:

- Certificate in Veterans Health: Meets CME requirements and would also be associated with special pay (Board certification currently carries a bonus of $2,000)
- Comprehensive Military History: All enrolled veterans would have a comprehensive military history taken which would be in the medical record but would also be coded in a registry and be available for education, outcomes analysis, and research use
- Registry Database: In addition to the military history on enrollees in the system, any veteran could register his military history and/or receive relevant information on issues of concern to him/her with updates (He/she would not get literature or calls unless these are requested)
- Web site: Any veteran (or health care provider) could access the previously established Military Service History web site

The educational program will both build on and feed into the Military Service History project. Lessons learned in its development will be used in the development of the registry program. The expected outcomes are improved sensitivity to the effect of military experiences and exposures on veteran patients health and attitudes, improved patient satisfaction, increased awareness of the occupational risks in a patient's history, and a data base for future research activities.

Plans for 2000 – 2005

- Education subcommittee
  - Develop proposal for certification process.
  - Recommend development / revision of approved seven education modules (in priority order): SCI, Gulf War, PTSD, Agent Orange, Amputation, Radiation, and POW Health.
  - Recommend other educational modules as indicated.
- Military History subcommittee
  - Develop format for comprehensive history.
  - Reviewing code sheets used for history / intake in VA.
  - Explore VA/DoD History and Physical Coupler (currently used by DoD in Gulf War CCEP) - Joint Application and Design meeting.

1998 & 1999 Achievement Highlights

- Steering committee established and had first meeting. Representation includes:
  - Academic Affiliations
  - Employee Education Service
  - Information Office
  - Military Veterans Health Coordinating Board
  - Patient Care Services
  - Public Health and Environmental Hazards
  - Readjustment Counseling Service
  - VBA
- Two subcommittees were established – Education and Military History.

CONCLUSION

The Under Secretary for Health recognized in the *Vision for Change* that there has been and will always be a need to designate certain clinical activities for special program status. The Under Secretary designated the current list of services as special programs with the understanding that the list is likely to evolve over time. Each existing or new special program is different and requires different attention by management in the field and in headquarters until the administration and delivery of the program is institutionalized in the VA health care system.

VHA's approach to the monitoring and management of these programs, as well as other key activities, includes performance measures. Initially, some of these measures have been process measures that focus on inputs to care. New outcome measures that have been and are being developed will be more valuable as they help monitor health outcomes defined in terms of physical, psychological, and social functioning. VA's commitment to these special emphasis programs and the important veteran populations they serve is unwavering.

CHAPTER 5

EDUCATION & RESEARCH

VHA is extensively involved in the nationwide training of physicians, medical residents, and associated health professionals and in conducting medical research that greatly enhances the quality of care provided to veterans within the VA system, as well as enhances the level of American health care in general. The training of future health professionals determines in large measure how health care will be provided in the future. The VA health care system plays a substantial role in improving future health care delivery modalities and quality of care by investing in the training and research activities of its health care professionals. This chapter covers highlights and forecasts for Health Professions Education, Employee Education, and Research programs.

VA benefits from its education and research programs in many ways. Research investigations are targeted on specific veteran problems and are intertwined with the continuing evolution of health care. Many of those educated in the VA system remain with VA following completion of their educational requirements. Such health care professionals are a valuable source to VHA in providing a "State of the Art" work force. Current and planned actions in the education and research programs are focused directly in support of the following VHA strategies:

- Provide an educational and training experience for medical students and residents
- Increase positions in physician primary care training
- Improve associated health professions clinical training by implementing profession-specific standards of excellence
- Increase the proportion of research projects that are demonstrably related to the health of veterans or to other missions of the Department

HEALTH PROFESSIONS EDUCATION

VHA conducts education and training programs to enhance the quality of care provided to veterans within the VA health care system. Efforts are accomplished through partnerships with affiliated academic institutions. Building on the long-standing and close relationships between VA and the Nation's academic institutions, VA plays a leadership role in defining the education of future health care professionals to help meet the rapidly changing needs of the Nation's health care delivery system. VA's education mission contributes to high quality health care of veterans in the following ways:

- A climate of scientific inquiry between trainees and teachers enhances quality of care
- Medical advances are applied more readily in an academic setting
- Supervised trainees participate in the provision of clinical care
- Educational programs enable VA to recruit highly qualified health care professionals

For the education mission, VHA's change strategy has emphasized alignment of excellent patient care with training of future health professionals. In this regard, VHA has provided important leadership for its academic partners during these times of great change throughout all of health care.

Plans for 2000 - 2005

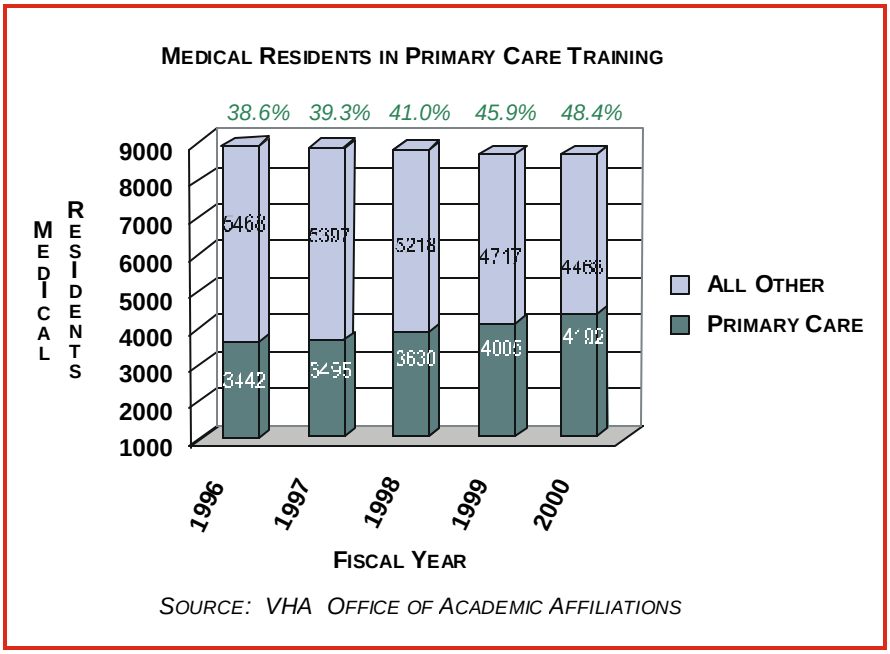
- During the third year implementation phase of the Residency Realignment Review Committee (RRRC) recommendations, VHA plans to downsize the final 25% of the target for specialty programs while developing additional primary care training opportunities. The following three goals were established to direct progress:
  - Increase the proportion of residents trained in primary care from 39.3% in 1997 to 48% in 2000.
  - Eliminate 250 specialty resident positions by 2000.
  - Reallocate 750 specialty resident positions to primary care by 2000.
- Implement a new interprofessional clinical education program directed at VHA's high priority patient care needs and special emphasis programs in 2000.
- Identify key drivers of resident and trainee satisfaction regarding their VA clinical training experience. The results of the survey will be used to implement targeted improvements to benefit both learners and patients in VHA.
- Provide a web site for the dissemination of information regarding VHA's academic mission and programs.

1998 & 1999 Achievement Highlights

Residency Realignment

- The first and second phases of the implementation of the RRRC recommendations (which called for replacing 1,000 specialist positions with 750 generalist positions over a three-year period and eliminating 250 specialist positions) were accomplished resulting in 75% of the changes.
- Chart 5.1 shows the actual (1996, 1997, 1998, 1999) and planned (2000) number of medical residency positions in primary care training versus all residency positions for VA.

Chart 5.1



1998 & 1999 Achievement Highlights (continued)

Primary Specialist Program

- The traditional definitions of generalist and specialist disciplines seemed to limit the options of the VA health system in this residency realignment process. Because veteran patients are frequently chronically and seriously ill, there was an imperative to combine both primary care access and the high levels of clinical expertise found in specialty disciplines. Therefore, the Office of Academic Affiliations (OAA) developed the Primary Specialist Program with advice from medical and psychiatry clinical leadership. Its scope includes the subspecialty training programs in medicine as well as neurology and psychiatry.
- Defined seven broad criteria for the residency training programs in VA that encompassed primary care of seriously ill patients by specialists. The definition of the criteria drew heavily on the definition of primary care by the Institute of Medicine. The criteria required explicit changes in organization of resident clinics and practices.
- Over 50% of internal medicine sub-specialty, neurology, and psychiatry residents in VA are participating in the primary care delivery within their discipline's residency training program.

National Medical Informatics Fellowship Program

- The Office of Academic Affiliations initiated support for disciplines that have considerable likelihood of becoming mainstream fields in medicine's future. One of these is Medical Informatics, the field that helps define how the information sciences—computers and other tools of the information sciences—can best be used in health care.

National Quality Scholars Fellowship Program (Previously noted in Chapter 2, *VA Health Care Quality Management*)

- Initiated program in 1998 to provide a two-year post-residency fellowship program in which physician-scholars will learn to develop and apply new knowledge for the ongoing improvement of health care services for VA and the Nation and will be leaders of the improvement needed in today's complex and rapidly changing health care environment.

Project for Improved Care at the End of Life (Previously noted in Chapter 4, *VA Special Emphasis Programs/Activities*)

- Through a generous grant of nearly $1 million from the Robert Wood Johnson Foundation, the Office of Academic Affiliations launched a two-year initiative to focus greater attention to training of resident physicians in end of life care. Working collaboratively with the Office of Patient Care Services, the project has focused on developing and integrating benchmark curricula for affiliated internal medicine residency training programs at 30 competitively selected VA sites.
- Raised the visibility of VA in the field of palliative medicine by creating an emerging leadership in end-of-life training and care. In addition, a web site and a VA-wide online conference have been launched. These have contributed to increased sharing of resources and information and resulted in improved care for dying veterans.

Resident Orientation Pocket Card

- The Resident Orientation Pocket Card was introduced in 1998 and has become part of the orientation to VA medical facilities for all medical students and residents.

1998 & 1999 Achievement Highlights (continued)

VA Medical School Affiliation Reviews

- The review of all VA medical school partnerships was completed and was valuable on several fronts:
  - The process helped to provide an accounting of the strengths and weaknesses of individual partnerships.
  - It provided an agenda for the future, which should serve to strengthen the affiliation over time.
  - The process strengthened new lines of communication and working relationships that should benefit VA's patients, students, and faculty staff as these affiliations move through a period of rapid change in medicine and medical education.

Associated Health Education

- Completed the field facilities' review and re-signing of all associated health professions affiliation agreements by 9/30/99.
- A revised methodology to allocate trainee positions has been developed to include more emphasis on the quality of profession-specific and interprofessional clinical education at the facilities.
- A new policy document has been issued that requires a reassessment of affiliations with associated health professions education programs to ensure alignment with the current and future health care environment and on programs that address the greatest needs of veterans.

EMPLOYEE EDUCATION

Organizations worldwide are focusing on how to preserve and foster human capital in today's rapidly changing information age. Knowledge is becoming our greatest competitive advantage and learning our greatest strategic skill. Reengineering requires a diverse, adaptive and skilled work force. Such a work force demands an innovative approach to train and empower employees to meet the challenges.

Successful organizations that recognize the relationship between job-related knowledge and skills and organizational performance are increasing their investment in employee education and training. In the past two years, VHA Employee Education System (EES) has taken bold steps to revolutionize learning within VHA to create a world-class employee education model that is directly aligned with and directly supports key VHA strategic initiatives.

Plans for 2000 - 2005

EES is committed to ensuring the learning revolution touches the entire VA community by becoming an innovative leader for all-employee learning. At the Department level, EES will work with representatives from across VA to address cross-cutting issues affecting the entire department. It will continue to expand partnerships with its key customers using sound business practices to create a learning infrastructure that: (1) supports innovation and best practices; (2) maximizes resource utilization; and (3) provides a return on investment. All initiatives will be guided by the following critical success factors:

Plans for 2000 – 2005 (continued)

- **Employee Focused**. Ensuring learning gets to the front-line employees. Offer learning opportunities that provide employees the core competencies they need to be highly successful in their current jobs, and help them develop skills to increase their employability as well.
- **Customer Driven**. Assessing and understanding the needs of our customers; be flexible in addressing them. Provide value-added training modalities that minimize impediments created by geographic and organizational boundaries to ensure learning opportunities are accessible to all employees and are available when needed, i.e., the right training, at the right time, at the right place.
- **Learning Linked to Performance**. Outcome/impact of the learning; demonstrate behavior/ performance changes. Provide learning opportunities that enhance employee job performance resulting in the promotion of patient wellness, improved patient care, and improved patient satisfaction.
- **Leveraging Resources**. Getting products out quickly; maximizing our resources and avoiding duplication; integrating technology with learning; demonstrating return on investment; establishing and maintaining learning partnerships, within and outside VHA, to expand educational opportunities for VA employees. For example, additional *Learning Maps*® are under development for "Quality," "Eligibility Reform," "Revenue Cycle," and "Benefits and Services to Veterans."
- **Improve Business Processes**. Optimizing internal support services and key program/product/ service design and delivery processes. For example, TEMPO is developing a web interface to enhance usage and will capture training information from computer-based and web-based training events.

1998 & 1999 Achievement Highlights

All Employee Learning

- Conducted an agency-wide conference, *Revolutionizing Learning: A Campaign to Energize Learning for All Employees* for over 350 participants, where participants developed solutions for current problems.
- Facilitated a variety of innovations including the High Performance Development Model, Patient-Provider Communication (Bayer) Training, and established education infrastructures.
- Developed the Revolutionizing Learning Website at http://vaww.lrn.va.gov/revlrn/ to aid in the continuation of the learning process and to serve as a key reference point for education and training resources across the One VA system.

Introduction and Implementation of *Learning Maps*®

- Introduced the *Learning Map*® process to VA and developed maps designed to be experienced by everyone in the organization – from the senior executives to the front-line employees – thereby providing a shared learning experience for the entire organization. This new and unique approach has enabled employees to grasp the "big picture" of the forces that are reshaping our organization and the way we work.
- Developed *Learning Maps*® that dealt with "Our Changing Healthcare Environment," "The Economics of Providing Care," "Delivering Care," "Our Journey of Change," and "Becoming One VA."
- Provided copies of the *Learning Map*®, videos, and supporting materials system-wide.

1998 & 1999 Achievement Highlights (continued)

Education Support to VA Care

- Working with a range of program officials and field representatives, numerous VA Care initiatives were developed including: training a cadre of more than 90 VA staff consultants in Primary and Managed Care strategies, supporting the VA Managed Care Consensus Conference, Developing Practice Management videos and materials, and the further development and dissemination of Primary Care educational modules.
- Provided a VA Care Consultation Team to thirty-one VHA facilities to review their VA Care and primary care processes and make recommendations for improvement.
- At one year after site visits, more than 50% of the 323 recommendations made by VA Care Teams had been implemented. Thirty percent of the medical centers had either partially or fully implemented 100% of their recommendations and 65% had either partially or fully implemented at least 75% of their recommendations.

Compensation & Pension (C&P) Examiner System

- Developed a CD-ROM to help improve the sufficiency rates of C&P exams. This multimedia environment provides just-in-time learning when the user wants and needs it by presenting appropriate answers to important questions drawn from a database of over 450 video clips of physicians, rating specialists, and other content experts. Sixty percent of the medical centers using the software achieved statistically significant reductions in insufficiency rates; none of the control medical centers achieved such reductions.

Training and Education Management Program (TEMPO)

- Developed in partnership with VISN 22, a program to collect and report information about education and training activities that facilitates the management of educational resources in a facility/network. TEMPO is a robust, easy to use software package that is now being used in 85 VA facilities spanning 15 VISNs. It provides individual VA facilities and Networks with information about employees' training history, services, courses, and compliance with VHA Performance Measures that has not been possible in the past. More significantly, the information can be used to manage education resources more effectively at the facility and VISN levels.

Leadership Development

- Continued to support initiatives associated with the High Performance Development Model (HPDM). Components include Performance Management, Competency Development, Performance Based Interviewing, Continuous Assessment, Coaching/Mentoring, and Continuous Learning Opportunities.

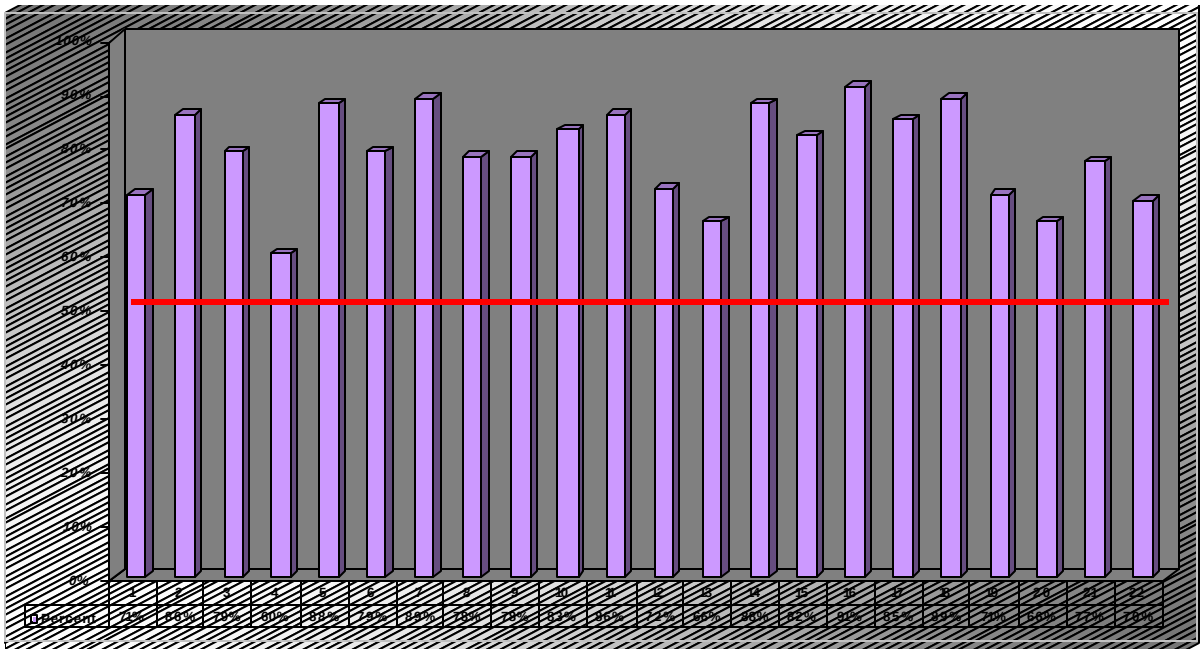
1998 & 1999 Achievement Highlights (continued)

Increase the Amount of an Employee's Paid Time that is Spent in Continuing Education to Promote and Support Quality Improvement, Patient Safety, and Customer Service

- 1998 goals were 50% of permanent employees receiving at least 20 hours of continuing education.
- 1999 goals were 50% of permanent employees receiving at least 30 hours of continuing education, ten of these hours must be for activities associated with Total Quality Improvement (Chart 5.2).

Chart 5.2

1999 Percentage of Employees Receiving Continuing Education
(50% of Permanent Employees equals Fully Successful)



Source: 1999 Network Performance Report

RESEARCH

As VHA continues its historical transformation, the Office of Research and Development maintains its dedication to its mission of discovering knowledge and creating innovations that advance the health and care of veterans and the Nation. The office's four divisions comprise a research enterprise that focuses on diseases and conditions that affect large numbers of veterans. The *Medical Research Service* studies fundamental biological processes to increase understanding of disease pathology, diagnosis, and treatment. The *Cooperative Studies Program* applies that knowledge through multicenter clinical trials of new therapies. *Health Services Research and Development Service* improves the effectiveness and efficiency of health care. *Rehabilitation Research and Development* works to minimize disability and restore function in patients disabled by trauma or disease. In 1998, the actual total research funding (both VA and non-VA) was approximately $1.012 billion, in 1999, the estimated total research funding (both VA and non-VA) was approximately $1.144 billion, and the estimated total research funding (both VA and non-VA) for 2000 is approximately $1.146 billion.

Each of the divisions has particular areas of expertise that increasingly cross the once-traditional boundaries to combine efforts and resources to achieve greater success. In addition, the research program seeks to translate that knowledge into practice by ensuring that new information is quickly made available to those who deliver care.

Plans for 2000 – 2005

- *The use of anticoagulant therapy to prevent thromboembolic complication in patients with dilated cardiomyopathy* has long been advocated, but little is known about the efficacy of this therapy and for whom the therapy will be effective. Current practice guidelines reflect this uncertainty. This study will compare the effect of three antithrombotic therapies in patients with congestive heart failure. Eligible patients will be randomized to treatment with aspirin, warfarin or clopidogrel. This international study will enroll 4,500 patients. This will require participation of up to 150 centers for a three-year enrollment period with all patients followed for a minimum of two years. Non-VA centers in the U.S. as well as centers in Canada and the United Kingdom will participate. This study will begin in January 2000 and end in December 2004.
- *Major trial launched to test new vaccine against shingles*. Shingles in older people is extremely painful and can be disabling. There is no effective method to prevent shingles nor an effective treatment for people who suffer from shingles lasting more than a month. This study will test a new vaccine for its ability to prevent shingles or reduce its severity and complications. The randomized, controlled trial will enroll 35,000 older veterans for a minimum of three years. If the vaccine proves successful, it will supply a safe and cost-effective means for reducing the severe impact of shingles and its complications on the health of older veterans. This study started in December 1997 and will end in September 2003.
- *Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE).* Coronary Heart Disease is the single leading cause of death among Americans. The COURAGE study is a large-scale, multi-center, randomized controlled trial comparing the effectiveness of angioplasty with medical therapy to medical therapy alone in treating patients with coronary heart disease. Cooperative Studies Program investigators are testing the hypothesis that angioplasty with intensive medical therapy is superior to intensive medical therapy alone, using the combined endpoint of all-cause mortality or non-fatal myocardial infarction. This international 6.5-year study involves more than 3,000 patients in VA and non-VA sites throughout the U.S. and Canada. This study began in December 1998 and will end in September 2005.
- The impact of visual impairment on aging veterans is known to be profound. A three-year study of blind rehabilitation outcomes is exploring the impact of blind rehabilitation on visually impaired veterans and is expected to help identify the best rehabilitation strategies for visually impaired veterans.

1998 & 1999 Achievement Highlights

Medical Research Service

- A new program, established in 1998, allows VA scientists to take novel approaches to studying biomedical problems common among veterans. The Research Enhancement Awards Program (REAP) supports multidisciplinary research, pilot studies, and training for young investigators. Two cycles of review have been conducted, resulting in REAP's focus on lung disease, bone disease, Parkinson's disease, heart disease and heart failure, kidney disease, gastrointestinal disorders, spinal cord injury, ulcer wound healing, cancer, multiple sclerosis, hepatitis C, Alzheimer's disease, and depression.
- Two research centers for the study of alcoholism were announced in 1999. Researchers in Omaha, NE will continue ongoing studies in the development of alcoholic liver disease. In West Haven, CT investigators will focus on the use of modern technology to increase understanding of the neuroscience of alcoholism. Both centers are funded for up to five years.
- Smoking is a major problem among veterans, contributing to a variety of related health problems. For smokers trying to quit, researchers found that those who took the medicine mecamylamine orally and used a nicotine patch had a higher success rate than those only using the patch.
- VA researchers identified a new part of the brain that takes part in the thinking process - the motor cortex, an area scientists previously believed was limited to controlling voluntary movements. Their finding is an important step in the quest to understand how the brain's higher functions work and perhaps ultimately identify new approaches to brain disorders such as cognitive problems.
- VA researchers and their colleagues recently reported that daily injection of parathyroid hormone (PTH) in mice increases bone mass by preventing the death of bone forming cells called osteoblasts. Their finding may point the way to potential new therapies for rebuilding bone in people with osteoporosis, the "brittle bones" disorder that afflicts millions of elderly Americans.
- In a study that may lead to relief for the 100 million chronic pain sufferers in the United States, VA researchers have discovered a way to deplete spinal nerves (neurons) that transmit chronic pain signals to the brain. Using a natural chemical messenger and a neurotoxin, they successfully shut down pain-associated neurons, leaving the others intact.

Cooperative Studies Program

- *New flu vaccine may provide better protection for people with lung disease.* VA researchers are trying to determine whether a new vaccine can protect patients who have chronic obstructive pulmonary disease (COPD) against influenza and its often-dangerous complications. COPD is common among VA patients. COPD patients are especially vulnerable to developing severe complications from influenza that include pneumonia, hospitalization, and even death. The standard flu vaccine, given by injection in the arm, prevents flu in only about half of patients with COPD. Recently, a new flu vaccine that is sprayed in the nose has been developed. This VA study, a randomized, multi-center trial that involves 4,000 people with COPD, will determine whether patients who receive both flu vaccines are better protected than those who receive only the standard flu vaccine. Researchers started vaccinating patients in the fall of 1998 to observe whether they develop flu. If successful, this new immunization regimen will save lives, prevent serious complications, and reduce treatment costs. This study may have significant implications for changing VA policy on vaccinating individuals with COPD against flu. This study started in July 1998 and will end in June 2000.

1998 & 1999 Achievement Highlights (continued)

- *Warfarin and Antiplatelet Therapy Study in Heart Failure (WATCH).* Congestive heart failure (CHF) remains an important clinical and societal problem. In the U.S. alone, it is estimated that more than 4 million patients suffer from CHF, with an annual incidence of more than 400,000 new cases, resulting in 40,000 deaths and 875,000 hospitalizations. Although there have been important advances in the pharmacologic treatment of CHF over the past two decades, CHF remains a very lethal condition.

Health Services Research and Development

- The Quality Enhancement Research Initiative (QUERI) is a comprehensive, data-driven, quality improvement program designed to rapidly translate evidence into practice for eight prioritized conditions: CHF, Ischemic Heart Disease (IHD), Diabetes, Stroke, Substance Abuse, Mental Illness, and HIV/AIDS. A six step process is used by multidisciplinary teams that bridge research and clinical care for each of the prioritized topic. Using the QUERI process, a systematic approach assures optimal patient outcomes for veterans and system-wide quality improvement for VA. All eight QUERI teams use quality management tools to assure that needed knowledge gets to the bedside as quickly as possible. An example of a quality improvement tool is the Stroke Management Toolbox and algorithm, now disseminated across VA that assists providers in using best practices to diagnose and treat veterans during the acute stage.
- HSR&D investigators produced critical information that will help patients with Type II Diabetes (non-insulin dependent) achieve the appropriate level of glycemic control and determine whether or not to start insulin therapy. This is particularly important to VA and the Nation because diabetes affects 10-16 million people in the United States and is one of the leading causes of morbidity, mortality, and health care costs in VA.
- The findings of an HSR&D study highlight the fact that many hospitalized elderly patients have inadequate nutrient intake that might be associated with adverse clinical outcomes. Numerous factors, prevalent in both VA and non-VA hospitals, contribute to this problem. The HSR&D study has been the impetus for VA to institute routine assessment of patients' nutritional status, in order to prevent nutritional deficits and identify problems early.
- HSR&D researchers examined the use of antipsychotic medications that are an essential component of the treatment of schizophrenia. Results of this study contributed to the selection of national performance measures for the VA Psychoses Guideline. This study will improve the quality of medication management, resulting in lower symptom severity and better patient outcomes.
- The Ambulatory Care Quality Improvement Study has linked patient reports on health status and satisfaction with clinical data. A computerized system packages all the information into concise reports for primary care providers, along with evidence- and guideline-based practice information. If a planned trial of the system at seven VA medical centers has positive results, the approach could be used throughout VA to improve the quality of ambulatory care.
- Research conducted by HSR&D investigators shows that community-based substance abuse treatment is highly effective. This study provides scientific evidence in support of a major change in health care delivery that is taking place throughout VA, and that is associated with substantial cost savings.

1998 & 1999 Achievement Highlights (continued)

Rehabilitation Research and Development

- Advances in functional electrical stimulation (FES), which uses wire implants and electrical impulses to replace non-functioning nerves, are increasing the independence of paralyzed persons. An FES hand grasp neuro-prosthesis, developed by the VA, provides users control through wrist movements. Tests are underway to determine if brain signals can control implants, allowing persons without voluntary wrist control to use the devices.
- The Scanning Laser Opthalmoscope is improving assessments of functional vision in patients who have developed dark spots in their field of view.
- Stroke in the dominant side of the brain often results in aphasia, a disorder affecting speech generation and understanding. New strategies for quantifying effort and communication may help put patients affected by aphasia back in touch with the world around them.

Increase the Percent of Research Projects that are Demonstrably Related to the Health Care of Veterans or to Other Missions of the VA

- In 1996, only 87% of the funded research projects were relevant to VA's health care mission. In 1998 and 1999, 99% of the research projects were demonstrably related to the health care of veterans or to other missions of the VA.

Conclusion

In re-engineering the health professions and employee education program and research program, VHA has successfully aligned training and investigation capabilities to more effectively address veteran needs and problems.

VHA's accomplishments and forecasts in the education and research programs represent a firm commitment to addressing the needs of the Nation within the context of priorities for veterans.

CHAPTER 6

EMERGENCY MANAGEMENT

One of the four missions of VHA is to ensure health care for eligible veterans, military personnel, and the public during DoD contingencies and during natural, manmade, and/or technological emergencies. This chapter reviews 1998 and 1999 accomplishments and presents future plans for VHA's emergency management program. All of these activities directly support the VA Strategic Goal to contribute to the public health and socioeconomic well-being of the Nation.

The Emergency Management Strategic Healthcare Group (EMSHG) and its national network of Area Emergency Managers coordinate:

- Disaster planning, response, training, and exercises
- Activation of the VA-DoD Contingency Hospital System
- Activation of the National Disaster Medical System (NDMS)
- Management of NDMS Federal Coordinating Centers throughout the Nation

VA also assists individual states and communities in times of emergency by:

- Providing direct medical care to victims of disasters
- Augmenting staff of community hospitals, nursing homes, and other medical treatment facilities
- Providing stress counseling to disaster victims and responders
- Furnishing critically needed supplies, pharmaceuticals, equipment, facilities, and other resources

To be prepared for both military and non-military emergencies, an organization must develop, test, revise, and continually update plans for many different disaster scenarios. Realistic plans require close coordination and training with personnel from other medical facilities, emergency medical systems state/local government agency staff, and volunteers. Through this contact and a cooperative effort, the emergency preparedness program greatly strengthens VHA's ties to the community.

VHA possesses extensive medical training and educational capabilities, including a dedicated Emergency Management Education Section, a nationwide video-teleconference system, hospital-based medical libraries, and the ability to provide professional accreditation. Emergency preparedness drills and related activities test the effectiveness of these training programs and capabilities, and keep skills honed for the real-life emergency events.

VA's emergency management program provides a national resource that is easily deployed and strategically placed throughout the country. VHA, as a large integrated health care system with a presence in every state, is able to respond rapidly with personnel, supplies, equipment, and other resources in times of emergency.

Plans for 2000 – 2005

Preserving the capability to respond to any kind of incident, from a local event to a major disaster, requires vigilant preparedness coordination and training. The following goals will guide VHA to dependably and efficiently meet its responsibilities to veterans and the public at large:

- Complete Continuity of Operations (COOP) Plans.
- Design and conduct risk-based response exercises.
- Train VHA staff to recognize and respond to consequences of weapons of mass destruction.
- Provide guidance to all facilities for "all hazards" disaster planning (to include weapons of mass destruction).
- Update VA/DoD Contingency Hospital System Bed Capacity estimates.
- Review and exercise casualty reception plans.
- Analyze contingency bed projections for VA and DoD planning.
- Develop disaster response "standard operating procedures" (SOPs).
- Maintain a roster of VHA employees with skills and training in disaster response.
- Improve bed reporting at VA-managed NDMS Federal Coordinating Centers.

1998 & 1999 Achievement Highlights

- Papal visit to St. Louis – Provided emergency management support staff and pre-positioning of pharmaceuticals.
- Nike Games – Provided emergency management support staff to assist health and medical activities.
- Economic Summit of the Eight – Provided emergency management support staff and pre-positioning of pharmaceuticals.
- Hurricanes "Bonnie," "Earl," "Georges," "Bret," "Floyd," and "Lennie" – Provided clinical and/or emergency management support staff to augment state and federal response efforts.
- State of the Union Address: 1998 and 1999 – Provided emergency management support staff and advanced positioning of pharmaceuticals.
- "Consequence Management 98" – Initiated a multi-agency exercise at Ft. Gordon, GA. This exercise was a major training event aimed at addressing the consequences of weapons of mass destruction incidents. Numerous federal, state, and local emergency response organizations (about 300 – 400 individuals) participated in the exercise (VISN 8).
- NATO 50th Anniversary: 1999 – Provided emergency management support staff and advanced positioning of pharmaceuticals.
- North Carolina Floods: 1999 – VA emergency managers and administrative staff supported state and federal response efforts.
- "Operation Provide Refuge" – Provided clinical and administrative staff to assist with medical services for the Kosovo refugees at Ft. Dix, NJ.
- Y2K Rollover: 1999 – Implemented the national VA Y2K Rollover operation at Martinsburg, WV.

1998 & 1999 Achievement Highlights (continued)

- "CATEX99" – Planned and participated in this major National Disaster Medical System exercise simulating a terrorist attack in Minneapolis, MN. A large number (400) of local, state, and federal participants were involved and "victims" were evacuated to other cities: Des Moines, Kansas City, Milwaukee, Detroit, and Cleveland.
- "Quake 99" – Initiated a multi-agency exercise in Blytheville, AR. This exercise was a major training event aimed at addressing the consequences of a major earthquake along the New Madrid fault.

CONCLUSION

Disasters are commonplace in today's world. Coordinated, prompt response and relief efforts are needed to reduce morbidity and mortality. VHA's emergency management capabilities are a fundamental component of local, state, and national resources. During 1998 and 1999, VHA responded to numerous emergency situations ranging from the potential – preparation for terrorist activity at the Economic Summit of the Eight, to the actual – civil disaster relief for Hurricane Georges victims. VHA also responded quickly and effectively to unexpected problems in its own facilities. Through these efforts, VHA provided continuous exemplary care to veterans while contributing to the public health and well-being of the Nation during emergencies.

In 1999, VHA completed a comprehensive Continuity of Operations Plan (COOP) and a Year 2000 Transition. VHA will continue to work with other public and private sector organizations to prepare and test emergency response plans that contribute to the public health of the Nation. VHA will continue to improve capabilities to limit the negative consequences of unplanned emergencies by assuring that the right people, supplies, and equipment are in the right place at the right time.

CHAPTER 7

ELIGIBILITY REFORM & ENROLLMENT

VHA made many organizational and service delivery changes during the years preceding eligibility reform, and has further modified operations both to implement Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, and to promote efficiency and effectiveness. Its efforts to improve access are occurring along with a fundamental transformation in the veterans national health care system — a focus on outpatient health care delivery; the delivery mode also emphasized by VHA since restructuring in 1995. Due in part to the provisions of PL 104-262, VHA is better able to achieve the goal of delivering the right care at the right place and time. VHA's continued reorganization has also opened the way for rapidly expanding and integrating VA health care programs internally and with community resources. VHA is becoming a more population-focused, community-based and prevention-oriented system, ensuring that veterans receive timely, accessible, and appropriate care. Preventive services have increased, as have appropriate use of outpatient settings for providing prosthetic devices, orthotics, and restorations.

In the last several years, VHA has faced the challenges involved in implementing primary care and the care management it implies, while moving from a hospital-based system to one that is primarily focused on providing services on an outpatient basis. Thus far, however, VHA has maintained the ability to provide acute inpatient, outpatient, and community-based care to all veterans, as medically indicated, and has been able to meet the health care needs of all enrolled veterans. Nonetheless, VHA continues to closely monitor changes in enrollment, access, outcomes, utilization, expenditures, system capacity, quality, and customer satisfaction.

ELIGIBILITY REFORM

Eligibility Reform

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, fundamentally realigned the access to VA health care for veterans. It eliminated the distinctions between eligibility for inpatient care and eligibility for outpatient care, expanded the spectrum of health care services available to eligible veterans, and based care delivery on patient need.

VHA can now:

- Provide health care in the most appropriate setting – inpatient, outpatient, community, or home
- Provide preventive care, primary care services, and prosthetic & orthotic devices on an outpatient basis
- Enroll veterans under the new enrollment priorities – Priorities 1 through 7 (Table 7.1)
- Provide care with an enhanced ability through contracts and sharing authorities, thus improving access to VA care in communities closer to where veterans live

Under eligibility reform, emphasis has shifted from what care a patient is eligible to receive, to what care an enrolled patient needs. "Need" is defined as any treatment, procedure, supply or service that is considered medically necessary when, in the judgement of the patients' clinical care provider and in accord with generally accepted standards of clinical practice, it will promote, preserve, or restore health.

The law established two groups of veterans who are eligible for care. The first group (mandatory) includes veterans to whom VA "shall" furnish any needed hospital care and medical services, but only to the extent and in the amount that Congress appropriates funds to provide the care. The second group (discretionary) includes veterans to whom VA "may" furnish any needed hospital care and medical services, but only to the extent that resources and facilities are available, and only if the veteran agrees to pay VA a co-payment in exchange for care.

At the end of the first year of enrollment (1999), VHA reported 4.068 million current enrollees or about 16% of the total veteran population. Of these, 81% (3.277 million) were mandatory enrollees or about 34% of the mandatory population. Of the 4.180 million total enrollees at the end of 1999 (including those who had died, became ineligible, or declined enrollment), 2.994 million or 72% had used VA health care services. Approximately 75% of the mandatory enrollees became patients, while only 54% of the discretionary enrollees used VA health care services. This high participation (access rate) for mandatory enrollees can be attributed to the ability of VHA, under PL 104-262, to provide less costly preventive care and a comprehensive package of health care services. The lower use rate of the discretionary enrollees can be attributed to their relatively higher alternative health care resources, e.g., other insurance coverage, public health programs like Medicare, personal preferences.

After the first two years of official enrollment, the end of 2000, VA projects that 40.6% of the mandatory veteran population and 4.2% of the discretionary population will be enrolled. VA also projects that in 2000, VA will treat 32.5% of the mandatory population and 3.7% of the discretionary population (14.8% of the total 2000 veteran population).

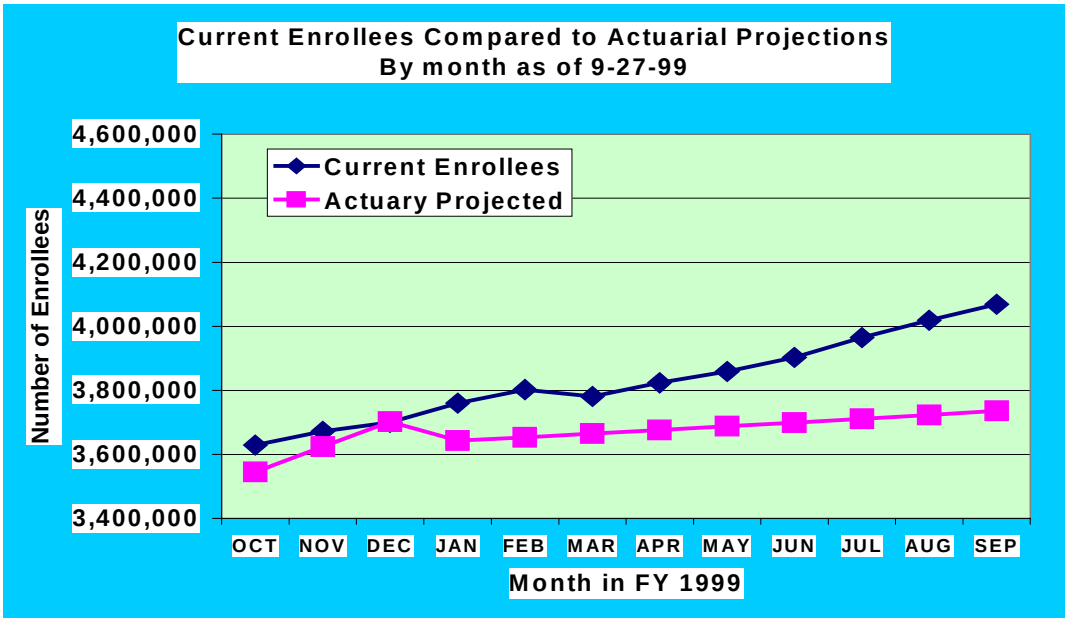
PL 104-262 also provided VA new sharing authority, under which VA medical facilities may enter into agreements with health care providers for the purpose of sharing and receiving health care resources. As of September 1999, VA's 1,571 sharing agreements included 767 standard VA/DoD agreements, 221 TRICARE agreements, and 583 agreements with academic affiliates and community providers.

Millennium Act

On November 30, 1999, the President signed PL 106-117, the Veterans Millennium Health Care and Benefits Act. This legislation authorizes a number of changes affecting enrollees, patients, and services, e.g., to enroll veterans awarded the Purple Heart into Priority Group 3 (see Table 7.1), to reimburse for the emergency treatment of certain enrolled veterans; and to expand long-term care services.

Chart 7.1 displays current enrollees compared to actuarial projections. The actual number of current enrollees started out slightly above projections in October of 1998 and increased during the subsequent two months. The 1998 actuarial projections (utilizing May 1998 Health Eligibility Center (HEC) data) were updated for January 1999 forward (utilizing January 1999 HEC data). Adjustments to the HEC data were required to remove 114,475 additional deaths and ineligibles of the reported 1999 current enrollees, the baseline actuarial database used in projection work. Current enrollees through September 27, 1999, reached 4,068,926. The national number of current enrollees is approximately 8% more than projected. Actual vs. projected enrollment will continue to be monitored closely.

Chart 7.1



Plans for 2000 – 2005

- VA will develop regulations to implement the new authorities from PL 106-117.
- VA will continue to explore new sharing agreement areas allowed with PL 104-262.

1998 & 1999 Achievement Highlights

- In 1998, developed a uniform benefits package to promote consistency in the services available to eligible veterans and to allow for more clinical flexibility in treating patients. Each VISN must make this benefits package available to all enrolled veterans, but has the flexibility to decide where and how the care will be provided.
- Published several annual reports to Congress on Eligibility Reform Implementation:
  - Preliminary Report on Eligibility Reform Implementation.
  - Report on Eligibility Reform Impact (PL 104-262, Section 106) for submission to the Senate and House of Representatives Committees on Veterans Affairs in December 1999.
  - Report to the Committees on Veterans' Affairs of Senate and House of Representatives (PL 104-262, Section 104), Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans, 1997, 1998, and 1999.
- Designed an Eligibility Reform Communications program as a communications and education outreach to veterans, employees, and other VA stakeholders. Specific strategies included kiosk development; Eligibility Reform Performance Support Tool (ERPST) - interactive CD-ROM product used to support front line employees; public service announcements (video and radio); comprehensive press kits of press releases, fact sheets, collateral material and other relevant information; pocket reference cards for staff; employee guidebooks; posters; and a descriptive brochure for veterans. Recognized with several awards within the public communications industry.

1998 & 1999 Achievement Highlights (continued)

- Conducted monthly teleconferences with eligibility reform coordinators, VISN offices, and Headquarters staff involved with eligibility reform and enrollment issues.
- Introduced two enrollment websites in 1999. The http://www.va.gov/health/elig provides stakeholders with up to date information concerning eligibility reform and current happenings; and http://www.vhacom.net was introduced to facilitate eligibility communications within VHA.
- Released the Eligibility Reform "Clearing the Path to Care: Examination of Eligibility Reform" Learning Map® to all facilities.

ENROLLMENT

October 1, 1997 through September 30, 1998 was used as a trial year for the VA enrollment process. An automatic application for VA health care enrollment was created for all veterans who had received care from October 1, 1996 through January 1998. Any veteran who was not enrolled automatically could apply for enrollment at any VA medical facility at any time. Enrollment officially began October 1, 1998.

Effective October 1, 1998, the Secretary may not provide hospital care or medical services to most veterans unless they enroll in the VA system. Some veterans continue to be eligible for services without enrollment: any service-connected veteran for treatment of a service-connected condition; for any condition of a service-connected veteran with 50% or greater disability; for any veteran released or discharged for a disability incurred or aggravated in the line of duty for the 12-month period following discharge or release from active duty for that disability; and for services excluded from the benefits package that are covered under other authorities.

The Eligibility Reform Act established the enrollment process as the primary tool by which VA manages access to health care within its limited resources. The Act specified seven categories of veterans in order of their priority for enrollment. Table 7.1 defines the seven categories in priority order.

Table 7.1

ENROLLMENT PRIORITIES FOR VHA HEALTH CARE

1. Veterans with service-connected (SC) disabilities rated 50% and above
2. Veterans with SC disabilities rated 30% or 40%
3. Former prisoners of war (POW), veterans with SC disabilities rated 10% or 20%, veterans discharged from active duty for a disability that was incurred or aggravated in the line of duty and veterans awarded special eligibility classification under Section 1151 of PL 106-117
4. Veterans who receive increased pension based on a need for aid and attendance or house-bound benefits and other veterans who are catastrophically disabled
5. Any veteran not listed above, including non-service connected (NSC) and any 0% SC veterans, who choose to be means tested and are unable to defray the expense of health care, i.e., annual income and net worth are below VA's means test thresholds
6. All other eligible veterans who are not required to make co-payments for their care including: WWI and Mexican Border War veterans, veterans solely seeking care for a disorder associated with exposure to toxic substances, radiation, or service in the Persian Gulf, and compensable 0% SC veterans
7. NSC and non-compensable 0% SC veterans who agree to pay specified deductibles and copayments

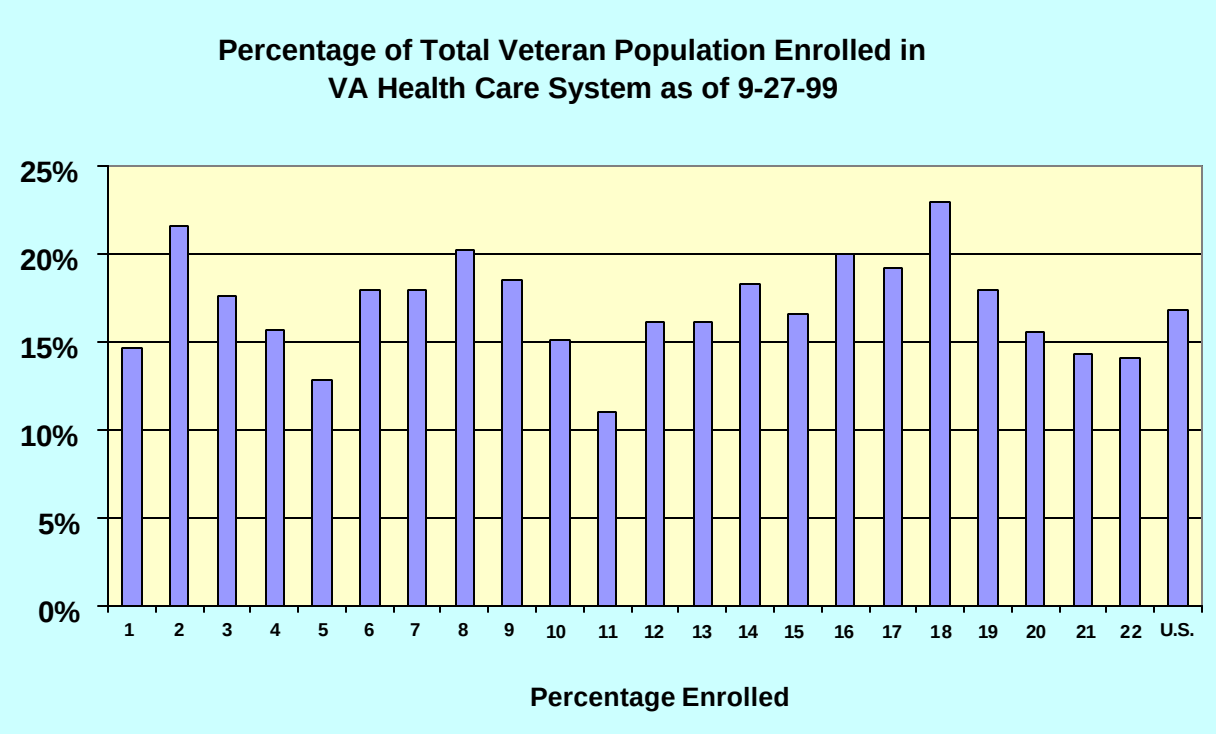
In response to Public Law 104-262, VHA has phased-in implementation of an enrollment management system. The system consists of several components including a field-based component that was released in 1997 to allow for enrollment data intake; a customer service center component that was implemented in 1998 to provide for external verification of eligibility data and notification to veterans of their enrollment status; and a National Enrollment Database (NED) component that is being developed to organize and store the official enrollment record information. The NED is expected to be released in 2000 and allows data to be organized and extracted for VHA patient data marts to support national reporting and querying of enrollment data. Until the NED is operational an interim enrollment database is used throughout the system that consists of enrollees, patients, utilization, and costs. This interim database is used for generating VA and congressional reports.

After an initial application for health care and enrollment is processed at the veteran's local VA health care facility, the HEC is responsible for verification of the veteran's enrollment information, assignment of the enrollment priority, and disposition of the enrollment application. Updated eligibility and enrollment information is automatically transmitted to VA facilities involved in the veteran's care. The HEC generates a letter that provides the veteran with notification of enrollment in VA's health care system and general enrollment information. The HEC also facilitates the re-enrollment process.

PL 104-262 requires that the Secretary of Veterans Affairs establish and operate a system of annual patient enrollment. Each year, the Secretary makes an enrollment decision based on available resources such that the quality of care and access to care will not be compromised.

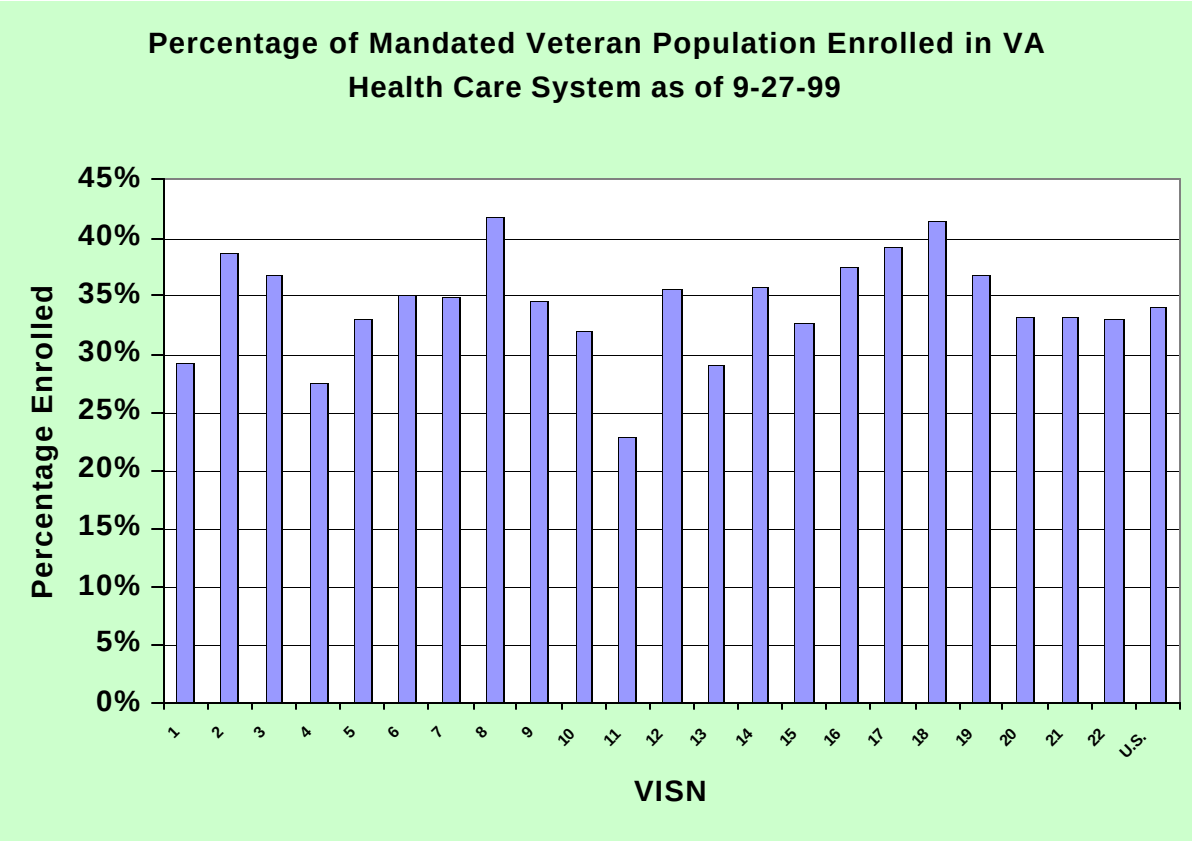
Chart 7.2 displays the percentage of total veteran population enrolled in the VA health care system as of September 27, 1999. VISN 11 has enrolled the lowest percentage – 11%, and VISN 18 has enrolled the highest percentage – 23%, of the total (mandatory and discretionary) veteran population residing within each VISN. At the national level, almost 17% of the total veteran population and 34% of the mandatory veteran population have enrolled in the VA health care system. (These data are based on total enrollees, including those who have died, become ineligible, or later declined enrollment.)

Chart 7.2



The total veteran population can be divided into two major groups – the mandatory veteran population and the discretionary veteran population. Chart 7.3 displays the percentage of mandated veterans who have enrolled in the VA health care system as of 9-27-99. Of the mandatory U.S. veteran population (all potential enrollees in Priorities 1 through 6), 34.12% were enrolled in the VA health care system as of September 27, 1999. VISN 18 had the highest enrollment with 41.53% of the mandatory veteran population, and VISN 11 had the lowest with 22.90%. (Note-The mandatory population in VISN 8 and the U.S. population here do not include veterans residing in Puerto Rico, so the actual percentage for VISN 8 and the U.S. would be slightly lower.)

Chart 7.3



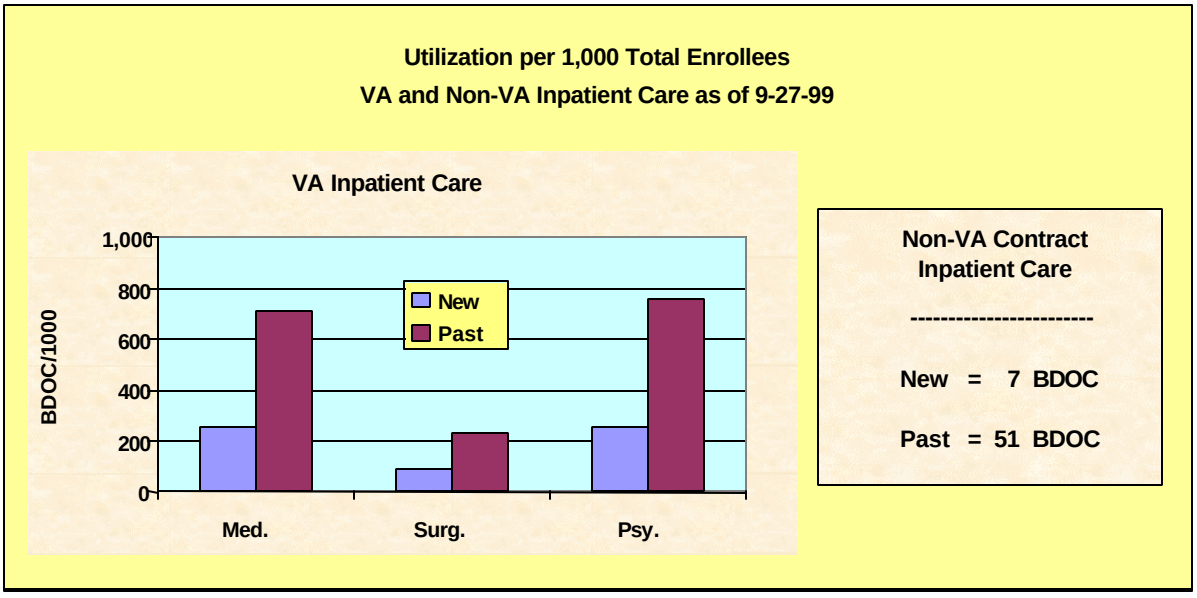
Plans for 2000 – 2005

- Continue to develop and implement software functionality and programmatic changes to meet enrollment, means testing, and income verification needs.
- Reengineer the technical architecture of the VHA database to facilitate fast, accurate, verification and processing of data and better enable the business mission.
- Continue implementation of a robust data quality improvement plan to improve the integrity and reliability of eligibility and enrollment data.
- Implement Millennium Act requirements regarding emergency care.

1998 & 1999 Achievement Highlights

- Announced two annual enrollment decisions allowing VA medical facilities to enroll all honorably discharged veterans (meeting certain eligibility requirements) who seek VA health care during 1999 and 2000.
- Conducted a survey of Veteran Enrollees' Health and Reliance upon VA in the spring of 1999.
- Developed VA and private sector (actuarial) projection models of future enrollees and expenditures.
- Published the final Rules and Regulations on "Enrollment-Provision of Hospital and Outpatient Care to Veterans" in the Federal Register/Vol. 64 No. 193. Effective date: November 5, 1999. This publication completed the Veterans' Health Care Eligibility Reform Act of 1996 that mandated implementation of a national enrollment system to manage the delivery of health care services.
- Implemented ***V***ist***A*** software to support enrollment and re-enrollment.
- Established a national Health Benefits Service Call Center (1-877-222-VETS) that also integrates with two enrollment reform web based sites (www.va.gov/health/elig and www.vhacom.net). The Health Benefits Service Center ensures that all veterans have a single point of access for requesting assistance and information on eligibility reform policies and enrollment. The Service Center handled nearly 346,000 calls, processed 65,000 requests for information brochures, and sent 75,000 enrollment applications.
- Generated approximately 4 million enrollment letters.
- Generated monthly enrollment reports to VA senior management using an interim enrollment database created through an MOU with Chiefs of Policy and Planning, Finance, Information, and Network offices.
- Deployed Means Test Sharing (MTS) software to allow sharing of means tests conducted by one facility or HEC with all the facilities involved in the veteran's care as the first step towards implementing Centralized Means Testing (CMT) in the future.
- Chart 7.4 displays utilization of VA and non-VA inpatient care (per 1,000 Total Enrollees). New enrollees utilization of VA Inpatient Care is significantly lower than past enrollees.

Chart 7.4



1998 & 1999 Achievement Highlights (continued)

- Table 7.2 displays the utilization (per 1,000 total enrollees) for various care settings. In each care setting below, the utilization rate for new users is significantly less than the past users.

Table 7.2

Utilization per 1,000 Total Enrollees for Various Care Settings as of 9-27-99

	VA Outpatient Care	Fee Basis Outpatient Care
New	3,112 visits	18 visits
Past	9,488 visits	117 visits

	VA Long-Term Care	Community Nursing Home Care
New	479 BDOC	58 BDOC
Past	2,043 BDOC	543 BDOC

CONCLUSION

VHA has managed well the changes resulting from the passage of Veterans' Health Care Eligibility Reform Act of 1996. VHA's approach has been to integrate a national VA health care system to encourage a rational, ethical, system of care that is responsive to veterans and provides the health care services the "Secretary determines to be needed." Determining what was "needed" became the most far-reaching legislative change in the VA health care system.

VHA is providing the right service to the veteran based on the needed health care in the most appropriate setting, whether that is inpatient, outpatient, community or home. The enrollment of veterans to receive VA health care should allow VHA to better understand the health care needs of the population served and, thus, improve the planning and execution of targeted health care programs. The uniform benefits package ensures that all veterans cared for by VHA receive consistent access to quality care and services. Preventive medicine programs and care management of individual patients increases access to the right health care service at an earlier stage to ensure that problems are identified before patient health is compromised.

CHAPTER 8

RESOURCE MANAGEMENT

VHA operates the largest integrated health care delivery system in the United States, providing care to over 3.6 million unique (a single individual enrolled in the system regardless of the number of times the person was treated) patients with nearly 751,791 inpatient stays and 37,799,423 outpatient visits in 1999.

MEDICARE SUBVENTION

VA has been interested in becoming a Medicare provider for several years. In 1995, the Vice President accepted, as a Reinventing Government (REGO) II initiative, VA's proposal to study the feasibility of receiving Medicare reimbursement for treating dual eligible higher income veterans at VA facilities. VA believes that, as a matter of equity, Medicare beneficiaries who are veterans should have the choice of using their Medicare benefits at VA. Medicare reimbursement is also a critical element in the Under Secretary for Health's long–range goals for the Veterans Health Administration to increase its non-appropriated funding sources.

VA, Health Care Financing Administration (HCFA), and Office of Management and Budget (OMB) worked together to develop a Memorandum of Agreement (MOA), which was signed in September 1997 and revised in May 1999. The MOA established the operating principles for conducting a Medicare pilot test at VA facilities. The proposal provides for a 3-year Medicare + Choice pilot where participation would be limited to higher income (Priority 7) veterans. Reimbursement rates would be 95% of what HCFA pays to private sector providers. Further adjustments would, in effect, lower VA's reimbursement rate even further from the private sector. VA would agree to meet all Medicare conditions of participation and would offer at least the same benefits as other Medicare providers.

Currently, with few exceptions, Medicare is not allowed to reimburse other government entities. Legislation is required to allow Medicare to reimburse VA. The Administration has submitted legislation over the last two years, which has not been introduced in Congress. Other bills have been introduced in the Senate and House; however, they differed from the Administration proposals to varying degrees. A Medicare reimbursement pilot remains a top priority for VHA and the Administration. VA will continue to pursue legislation, similar to that already granted DoD, for a VA Medicare pilot project.

REDUCE COSTS AND IMPROVE THE REVENUE STREAM FOR THE HEALTH CARE SYSTEM

VHA strategies are aligned under the VA objectives in the VA Strategic Plan. These strategies, in turn, are aligned with outcome-oriented performance measures. Reducing costs and improving the revenue stream for the health care system is a key VHA strategy. Shifting the focus of health care delivery from inpatient to outpatient care is a key component to the stated VHA strategy. VHA continues to monitor and track several performance indicators that relate to the shift of resources from inpatient care to generally less costly outpatient care. These are:

- Bed days of care per 1,000 unique patients served
- Percent of surgeries and procedures done in an ambulatory setting rather than an inpatient setting
- Number of users of the health care system
- Percent of operating budget obtained from non-appropriated sources

Plans for 2000 – 2005

- Continue to decrease bed days of care, as appropriate.
- Increase percent of surgeries and procedures done in an ambulatory setting.
- Increase number of users of the health care system.
- Increase percent of operating budget obtained from non-appropriated sources.
  - Medical Care Cost Fund (MCCF) – with complete interviewing of patients, effective pre-registration and similar efforts, VHA expects to increase the number of eligible, unique patients with reimbursable insurance by 8%. The new enrollment process for veterans in the VA health care system is also expected to assist in this endeavor.
  - Sharing reimbursements.

1998 & 1999 Achievement Highlights

Bed Days of Care (BDOC) per 1,000 Unique Veteran Users

VHA has used this measure as a proxy for the efficiency of its health care system until more refined unit cost measures are identified and developed. Bed days of care continues to be tracked as an indicator of the shift from inpatient to outpatient care. Reducing bed days of care is a key performance measure in the VA Strategic Plan to reduce costs and improve the revenue stream for the health care system.

- Bed days of care continued to decline, and this decline enabled the system to shift resources in order to meet projected demand arising from an expanded and improved eligibility system. National acute BDOC per 1000 unique patients were 2,525 in 1996, 1,782 in 1997 and 1,333 in 1998 BDOC by VISN.
- As of September 1999, national acute BDOC per 1000 unique patients was 1,136.

Surgical Procedures Performed in an Ambulatory Setting

Networks continue to shift the focus of health care delivery from the inpatient, hospital-based setting to ambulatory settings in an effort to enhance both quality and patient satisfaction, reduce cost, and increase efficiency. All networks are increasing the number of surgeries and other procedures performed on an ambulatory basis at the same time that they are decreasing the number of operating beds and bed days of care.

- For 1998, eleven surgical procedures were targeted for measurement regarding performance in the ambulatory setting. The networks energetically pursued this strategy.

1998 & 1999 Achievement Highlights (continued)

- For 1999, eight procedures were targeted for measurement regarding performance in the ambulatory setting. Some of the criteria and methodology were changed from previous years. Table 8.1 reflects recomputed 1997 and 1998 national averages and ranges to reflect the 1999 criteria and methodology.

Table 8.1

PERCENT PROCEDURES PERFORMED IN AN AMBULATORY SETTING

	Arthro-scopy	Breast Biopsy	Colon-oscopy	Cysto-scopy	Eyelids	Hernia	Lapro-scopy	Lens/ Cataract
1997 Nat'l Average %	85	87	87	87	89	72	68	83
1998 Nat'l Average %	92	92	91	92	94	83	81	94
1999 Nat'l Average %	93	92	92	93	95	86	81	96

SOURCE: 1999 NETWORK PERFORMANCE REPORT

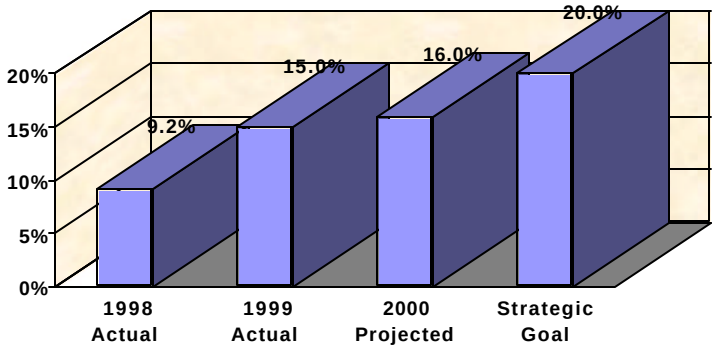
Increase the Number of Users of the Veterans Health Care System

Efforts to improve access are occurring in the midst of a fundamental transformation in the VA's national health care system – a focus on outpatient health care delivery. In keeping with this evolution, both VHA and its community of stakeholders agree that VA health care must become more population-focused, community-based, and prevention-oriented; all to ensure that veterans receive timely, accessible, and appropriate care. VHA intends to provide services to the largest number of veterans possible within the available resources. This issue has previously been discussed in more detail in Chapter 7, *Eligibility Reform and Enrollment*.

- Reorganization opened the way for rapidly expanding and integrating VA health care programs internally and with community resources.
- In 1998, unique patients treated increased by 9.2% from 1997. This surpassed the goal set for the Network Directors. In 1999, this was not a network performance measure.

Chart 8.1

PERCENT INCREASE FROM 1997 IN UNIQUE PATIENTS TREATED



SOURCE: 2000 VHA PERFORMANCE PLAN

1998 & 1999 Achievement Highlights (continued)

Increase the Percent of the Operating Budget Obtained from Non-Appropriated Sources

VHA has decreased its reliance on appropriated funds because of a five-year freeze on the VA medical care appropriation arising from the Balanced Budget Agreement. VA has been proactive in its efforts to secure funding by supplementing the medical care appropriation with alternative revenue sources.

Faced with 3.5 to 4 percent inflation each year (which will be partially funded by anticipated revenues from third-party collections through the Medical Care Cost Fund, sharing reimbursements, and management efficiencies), Medicare revenue has been one anticipated source of additional funds. This VHA strategic target has also been identified as a key performance goal in the VA Strategic Plan, 1999-2003, to meet the general goal of reducing costs and improving the revenue stream for the health care system. The future success of the VA health care system may depend as much on diversifying our funding base as on any other strategy.

Medical Care Cost Fund (MCCF). A critical element in the process of increasing collections from third party insurance payors is assuring insurance identification. Public Law 105-33 allows networks to retain their MCCF recoveries. A pre-registration software package was developed and implemented that is used to obtain insurance/employment information from patients at their residences prior to scheduled outpatient visits. The Application for Medical Benefits, Form 1010, was changed to include more comprehensive questions regarding insurance. Each medical center is expected to use this package. A diagnostic report was developed to monitor progress in the intake process of both registration and pre-registration.

- Pre-registration over 18 months resulted in 102,155 “demographic changes” made in the MCCF database which in turn resulted in an increase in collections of over $11.5 million.
- At the beginning of 1998, the national average for unique patients treated with reimbursable insurance was 15%. With improved interviewing of patients, effective pre-registration and similar efforts, VHA expected to increase the number of eligible, unique patients with reimbursable insurance by 8% by September 1999. This goal was met when the national average reached 23.4% in September 1999.
- Hired Network Revenue Coordinator and established a Network Revenue Team. (VISN 3, 10)

Sharing Reimbursements. VHA has a long history of maintaining beneficial sharing agreements with its medical school affiliates and allied health partners. New sharing arrangements and alliances within and outside VHA are crucial to the implementation of the VISNs as virtual networks of care for revenue generation and/or cost savings. Under the expanded health care resources sharing authority granted to VHA in the Eligibility Reform legislation, VHA may enter into sharing agreements or contracts with any health care provider, or other entity or individual. VHA may enter into sharing contracts to acquire (“buy”) health care resources, to provide (“sell”) health care resources, or to exchange health care resources. These arrangements can be between neighboring VHA medical centers, with other governmental providers such as DoD, and with private sector providers.

- VHA Strategic Target for 1998 was to increase the number of facilities with CHAMPUS or TRICARE agreements to 65 from 52 in 1997. Actual 1998 accomplishment was 120 facilities.
- Teleradiology agreement with Immigration and Naturalization Service. (VISN 12)
- Modified TRICARE billing process to improve collections and conducted a two-day workshop for network-wide training of billing and collection staff. (VISN 8)

1998 & 1999 Achievement Highlights (continued)

- Implemented a "Revenue Enhancement Team" that visited network facilities. (VISN 16, 17, 18)
- Implemented a national interagency agreement with Federal Bureau of Prisons covering provision of viral load testing. (VISN 17)

Enhanced Use Leasing. The Enhanced Use Leasing program was created by special legislation to assist VA in utilizing underused and available capital assets to the benefit of VA. Under this program, VA can issue a long term lease of its excess buildings or land (up to 75 years) and receive, in return, various forms of compensation including income, services, shared space, or other creative consideration that provides VA benefits it would not otherwise be able to obtain. The program's near-term focus is to develop and explore projects in support of medical center and network initiatives to generate additional revenues, achieve operational savings, and obtain needed facilities/programs which otherwise would be unaffordable.

- To date, accomplishments include: power plants, skilled nursing facilities, hospices, assisted living centers, senior housing, transient lodging, child care centers, parking garages, golf courses, medical and administrative office buildings, and campus consolidations.

Implementing the New Procurement Policies. Initiatives that are assisting VHA in streamlining the procurement process and saving dollars that can be redirected to direct patient care activities are: International Merchant Purchase Authorization Card (IMPAC) program which was fully implemented in 1997 and changed the way that VHA manages procurements and payments for micro-purchases; the standardization of medical products; and the Pharmacy Benefits Management group.

- The policy of standardization of medical products allows VHA to use single award contracts and its concentrated buying power to secure high quality products at the best possible prices.
  - Thirty-six contracts were awarded that cover over 500 medical and surgical products. The value of these contracts is nearly $21 million.
  - The projected annual cost avoidance as a result of these contracts is estimated at $5.3 million.
- Cumulative savings on the national pharmacy contracts from 1996 to 2000 total more than $653 million.
- Implemented Network Business Center. (VISN 12, 15, 22)
- Consolidated procurement contracts for 19 high cost/high volume items. (VISN 8)

Refinements to the Veterans Equitable Resource Allocation (VERA) System

In 1997, VHA implemented a new system to efficiently and effectively allocate its then $17 billion congressionally-appropriated health care budget to its 22 networks. This new methodology, the Veterans Equitable Resource Allocation system, was created to address previously documented problems and to improve the resource allocation system in order to support VHA's goal to provide excellence in health care value. VERA helps VHA to treat the greatest number of veterans having the highest priority for health care. It accomplishes this by:

- Allocating funds equitably according to the number of veterans having the highest priority for health care
- Recognizing the special health care needs of veterans
- Creating an understandable funding allocation system that results in having a predictable budget
- Aligning resource allocation policies to the best practices in health care
- Improving the accountability in expenditures for research and education support
- Tracking and complying with congressional mandates

VERA is an important component of VHA health care to ensure that veterans across the country have equal access to VA health care and that tax dollars are spent wisely. In combination with improvements in the network organizational structure, eligibility reform, authorization to retain third party collections, and other changes underway in the veterans health care system, VERA will help ensure the long-term financial viability of the VA health care system and will allow it to serve as a model of integrated health care delivery.

The following guiding principles were used by networks in providing 1998 and 1999 allocations below the network level. Network allocation systems must:

- Be readily understandable and result in predictable allocations
- Support high quality health care delivery in the most appropriate setting
- Support integrated patient-centered operations
- Provide incentives to ensure continued delivery of appropriate special care
- Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal
- Provide adequate support for the VA's research and education missions
- Be consistent with eligibility requirements and priorities
- Be consistent with the networks' strategic plans and initiatives
- Promote managerial flexibility (e.g., minimize "earmarking" funds) and innovation
- Encourage increases in alternative revenue collections

Plans for 2000 – 2005

- Refinements to the VERA methodology in the 2000 allocation process for application:
  - **Basic Care** – Differences between the fully vested patient and the occasional user have been further refined. For 2000, Basic Care patients will consist of two groups: fully vested, those who rely on VA for their care, and non-vested, those who use some VA health care services but are less reliant on the VA system. A patient is considered fully vested in the veterans health care system if he or she has used inpatient services or if he or she received an appropriate, detailed medical evaluation during the past three years. This medical evaluation is determined through the presence of an appropriate Current Procedural Terminology (CPT) code. By applying relevant CPT codes to outpatients seen in 1996, 1997, and 1998, and counting the inpatients for those same years, vested patients have been identified for the 2000 VERA. Separate prices for both vested and non-vested workload have been established.

Plans for 2000 – 2005 (continued)

- **2000 National Average Prices** – Basic Non-Vested Care is funded at the rate of $105. Basic Vested Care has a price of $3,249. The 2000 price for Complex Care is $42,153.
- **Other Patient Classification Changes** – The following series of patient classification workload refinements were approved for implementation in the 2000 allocation process.
  - The four Transplant VERA classes are combined into one class, which moves from a one-year designation to a three-year designation. The three-year designation recognizes the extreme high cost of transplants that continues beyond the initial procedure year.
  - Compensation and Pension Exam patients are funded as workload in VERA, with assignment to the VERA Price Group indicated by their level of care. The VERA class title "One Administrative Visit" will be changed to "Compensation and Pension Exams."
  - The Blind Rehabilitation VERA Patient Class is converted from a three-year designation to a one-year designation. This was done because the average cost of caring for a Blind Rehabilitation patient declines significantly after the first year and the cost in the following years is not necessarily associated with the treatment provided in a Blind Rehabilitation center or the patient's blind condition.
  - The VERA Patient Class, "End Stage Renal Disease (ESRD) - Home Care" is combined with the ESRD Class, and contract workload is now captured for VERA funding.
  - Collateral Visits are no longer funded in VERA.
  - All workload associated with Home Care is considered the same without regard to provider source or designation.
  - The four HIV/AIDS classes are redefined into two: one for Complex Care related to infection or malignancy, and for patients on specific antiretroviral HIV medications; and one for Basic Care (all other HIV cases).
  - The VERA Patient Class "Alcohol and Drug Abuse" is renamed "Addictive Disorders."
- **Geographic Price Adjustment** – The geographic price adjustment has been changed to adopt the labor index methodology recommended by PriceWaterhouseCoopers LLP in the *Veterans Equitable Resource Allocation Assessment Final Report*. This methodology uses a national market approach in the formula to create the index instead of network level staffing patterns.
- **Research Support** – Networks will pass research support funds through to each medical center and the medical centers will obligate funds to support the salaries of clinician-researchers and other research related expenses. Also, VHA will implement a system to ensure the accurate accounting of the Medical Care appropriation spent in support of research.
- **Equipment** – The new equipment allocation methodology will be fully implemented and is based completely on VERA Basic and Complex Care workloads.
- **Non-Recurring Maintenance (NRM)** - Non-Recurring Maintenance (NRM) will be changed over three years from 90% of the NRM dollars allocated based on an index-adjusted cost of construction, and 10% based on patient care workload to 100% of the NRM dollars allocated based on patient care workload adjusted for cost of construction. This was accomplished by using 100% of the patient care workload for each network and adjusting for the cost of construction using the Boeckh Index, which is an external inflation index that measures the relative cost of building and/or renovating space. 2000 will be the second year of the three-year phase-in.

Plans for 2000 – 2005 (continued)

- For 2001 and beyond, the following future changes to VERA are being considered:
  - **Care Across Networks** – A Care Across Networks Workgroup studied the need for a transfer pricing system to cover veterans who receive care outside of their home network (e.g., northeast networks would reimburse southern networks for the care provided to veterans who travel south in the winter). The group recommended implementation of a default pricing system based on Medicare rates, modification of the current billing system, and preauthorization to ensure that care provided is clinically appropriate. The proposed transfer pricing system preauthorization will be tested in 2000 and 2001. VA will continue to use Pro-Rated Person (PRP) concept pending VHA's decision on transfer pricing to ensure that care is compensated.
  - **Patient Classifications** – In the spring of 1998, VHA established the VERA Patient Classification Workgroup whose mission is to review the patient classification structure and recommend improvements as needed. When the Group started, there were 25 Basic Care Group Classes and 29 Special Care Group Classes. Based on the work of this Group, VHA will go into 2000 with 18 Basic Care Classes, and 24 Complex Care Classes. In 2000, the Workgroup will complete a review of the feasibility of classifying patients on the basis of diagnostic and functional data instead of utilization characteristics - they will evaluate whether the percentages of total General Purpose funding attributed to Basic Care and Complex Care should be updated to reflect the most recent actual expenditures between these two components by the networks.
  - **Evaluation of Patient Health Status** – VERA adjusts for the differences in complexity or case-mix of patients across networks by providing a higher price for Complex Care patients as compared to the prices for Basic Vested Care and Basic Non-Vested Care patients. Nevertheless, there has been feedback from internal and external stakeholders that they believe VERA may not distinguish adequately the differences across VISNs for patients' health status. In April 1999, VA retained a contractor, AMA Systems, Inc. and its sub-contractor CNA Corporation, to determine the relative status of patient health care across VA's 22 networks, and to the extent those differences cause disproportionate resource consumption in the affected networks that go beyond current VERA adjustments. AMA Systems began work in May 1999, and submitted a report to VA in February 2000 and the contract has been extended to July 31, 2000 to include the analysis of 1999 data in the final report. The VHA Health Services Research and Development Office is conducting a longer-term study that parallels the contractor's evaluation of patient health status across the 22 networks. The results of each of these studies will be given to VERA workgroups to evaluate whether further future refinements to VERA are needed.
  - **Review of Resource Allocation to Rural Areas** – VA amended its evaluation of patient health status contract study to also include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The contractor will determine whether there are differences in costs for care across VHA's 22 networks due to provision of care in rural settings.

1998 & 1999 Achievement Highlights

- Funding shifts begun in 1997, continued to be implemented and refined to ensure effective resource management. The phased-in model moved approximately $180 million in 1997. Capping gains and losses again in 1998, $239 million moved among networks and $165 million moved in 1999. Changing factors such as funding levels, workload, and VERA model revisions each year affect the amount of the shifts. These changes account for more than the initial estimate of $500 million having been shifted.
- VHA issued a formal policy directive to the networks establishing resource allocation principles that move the organization toward accomplishing its systemwide goals and objectives.
- Comparing 2000 funding with 1996, the last full year before VERA was implemented, twenty networks received funding increases and two networks received less funding. Nine networks increased by 20% or more, with the greatest increase at 42%. Funding decreases were limited to 5% for each year when comparing 1999 to 1996. No caps or adjustments were applied for the 2000 funding level.
- Congress included provisions in the 1998 budget that allows VA to retain medical care collections rather than return them to the U.S. Treasury, as previously required.

Refinement of the New Capital Investment Policy

VA revamped its capital planning process in 1997, with the establishment of the VA Capital Investment Board (VACIB). This was in part due to criticism from OMB and also to legislatively mandated changes pertaining to the use of funds for capital assets. The revised process was originally based on OMB's *Capital Programming Guide*, and used during the 1999 planning and budget process. [In 1998, a private contractor surveyed other government entities and private industry to determine best capital planning practices that could be adapted for VA use. Twenty of the 28 identified best practices were incorporated into the revised 2000 VA Capital Investment Planning Process. One of the major improvements to the process was the addition of a priority-scoring system, based on the Analytical Hierarchy Process (AHP)]. Two new major criteria will be added to the capital investment methodology for the 2001 cycle. VHA used the Capital Investment Methodology Guide, produced by the private contractor, in conjunction with various training sessions to assist the VISNs in formulating their own capital asset plans.

This continually evolving process assists in fulfilling requirements of the Government Performance and Results Act of 1993 and the Clinger-Cohen Act of 1996. Specifically, this process requires that capital investment proposals be directly tied to program plans, and that each capital project be evaluated to determine how much it would contribute to achieving predetermined strategic program goals.

To summarize a fiscal year's capital planning efforts, a Department Capital Plan, which includes a description of all capital asset proposals approved by the VACIB, is submitted to OMB in support of VA's annual budget request. To date, VA has completed Capital Plans for 2000 and 2001.

Plans for 2000 – 2005

- VHA will continue to ensure that proposed investments support program goals and objectives in the strategic plan. In addition, ongoing capital investments will also be reviewed according to the post-implementation guidelines issued by OMB.
- VHA will implement the capital asset realignment for enhanced services (CARES) program.
- Two new major criteria – Threat Mitigation and Special Emphasis Programs – were added to the VACIB application process for VHA proposals beginning in the 2001 cycle.
- Asset Disposal legislation provides incentives to VA to dispose of excess or underutilized property beginning in the 2000 cycle.

1998 & 1999 Achievement Highlights

- In 1998, published capital asset planning guidance for use by the VISNs in formulating their own capital asset plans.
- In 1998, awarded 35 design or major construction project contracts, totaling $176.7 million by the Office of Facilities Management in Headquarters.
- In 1998, physically completed 19 major construction projects, which were managed by the Office of Facilities Management, totaling $490.2 million.
- Funding for six VHA Major Construction Projects totaling $128 million was included in the 1998 appropriations bill.
- In 1999, applied the new VA priority scoring system to all major construction and information management capital investment projects proposed for the 2000 budget.
- In 1999, completed the second VA Capital Asset Plan with VHA including all investment proposals approved by the VACIB.
- Funding for five VHA Major Construction Projects totaling $129 million was included in the 1999 appropriations bill.

Conclusion

Shifting the focus of health care delivery from inpatient to outpatient care is a key component of VHA's strategy to reduce costs and improve the revenue stream for the health care system. VA's business is health care not hospital care or any other site-specific type of health care. Hospitals, clinics, hospices, and other venues are merely the tactics by which health care is provided. By focusing on both quality and resource management, VHA can maximize their funds.

CHAPTER 9

INFORMATION MANAGEMENT

The mission of VHA information management is to provide exceptional information technology (IT) and services to support delivery of the best health care possible to veterans. VHA Office of Information (OI) has made great strides in supporting both VHA's field offices and veterans. Emphasis on the "One VA" concept has lead to new, unique, and improved avenues for meeting IT goals and objectives. VHA's overall goal is to provide world-class service to veterans and their families through the effective management of people, technology, processes, and financial resources. To achieve that goal, management of IT resources plays a major role in the following objectives:

- Jointly developing community services within the VA and between other agencies
- Providing access to VHA stakeholders through new communication strategies such as the universal implementation of Microsoft Exchange and the Internet
- Developing, implementing, and publishing an Information Technology architecture that supports the current and future processing needs of the Department
- Implementing a web-based interface to provide information to the veteran community
- Sharing of clinical data in partnership with both internal and external entities

VHA's IT goals and objectives are at the center of health care delivery. Many of the central tenets of "One VA" are essential elements of modern health care delivery with its emphasis on integration of care and access to quality care and services. VHA is relying more heavily on IT to improve patient access to quality, efficiency, and cost-effective delivery of services. The major information system that automates all major clinical management and administrative functions throughout VHA is called the Veterans Health Information Systems and Technology (***VistA***). ***VistA*** includes both "in-house" developed and commercially purchased software. The availability of reliable and timely information is critical for all clinical and administrative decisions. VHA IT planning goals are based upon meeting VHA's objectives and in maintaining its national leadership position in health care information management.

This chapter discusses VHA's involvement in:

1. Improving its technology, the Infrastructure Project, MS Exchange implementation, and the Internet/ Intranet functionality project
2. Information sharing among and between VA organizational elements, i.e., the automated medical information exchange project
3. Increasing the availability of electronic patient medical information between facilities, i.e., the clinical information resources network, the computerized patient record system, the government computer-based record, and the imaging project
4. Expanding support for administrative decision-making, i.e., Decision Support System (DSS) and Enrollment System Project

IMPROVING VHA'S TECHNOLOGY INFRASTRUCTURE

VHA has enhanced the telecommunications infrastructure for the VISNs, health care facilities, and headquarters in order to improve the electronic means by which VHA employees communicate. The telecommunications infrastructure addresses sending and receiving of voice, data, video, and images at acceptable speeds over local area networks and wide area networks (WAN), and to provide the communications foundation to promote effective management within the VISN structure. The infrastructure includes fiber optic backbones, local area network hubs/switches, and multimedia mail servers and software for all VA medical facilities, as well as upgrades of the WAN nation-wide which link VHA facilities together. The infrastructure is the foundation for VHA's enterprise information systems interconnectivity, and is central to providing the faster and more reliable communications necessary in today's health care business environment.

Infrastructure Project

This project, formerly known as the Telecommunications Infrastructure Project, was designed to provide an enhanced telecommunications structure that provides primary support for the computerized patient record system, ***VistA*** imaging, DSS, drug utilization, electronic document imaging, desktop video-conferencing, tele-medicine, MS Exchange, office automation, and access to the Internet and the World Wide Web. The goal of this project was to make more complete, timely, and accurate clinical and management information available to VHA health care providers and managers.

Plans for 2000 – 2005

- Implement actions necessary to activate the core ATM switching fabric that will be the virtual private backbone within the Sprint Public Network under the FTS2001 contract.
- Continue improvements to the existing WAN Frame Relay architecture to provide increased performance and decrease congestion.
- Develop site-specific implementation plans and statement of work to address reported findings and recommended improvements at OI Field Offices (OIFOs).

1998 & 1999 Achievement Highlights

- In 1998, decentralized Phase IV, the facility improvement phase, to the 22 VISN Chief Information Officers.
- In 1998, submitted VISN implementation plans to headquarters. Implementation efforts are in progress.
- In 1998, initiated a follow-up project to review telecommunications infrastructure conditions at the OIFOs.
- In 1999, completed Phase IV implementation objectives in VISNs 7, 13, 14, 18, and 19. All other VISNs are 87% complete nationally.
- In 1999, completed local area to WAN interface interim fixes at the six VHA OIFOs which route VA national traffic across the frame relay network to improve network performance.
- In 1999, implemented a new WAN network with Sprint under the FTS2001 contract. As a consequence, a subsequent decision was made that all VA resources would now be directed toward the new FTS2001 network implementation.

Implementing Microsoft Exchange

Microsoft Exchange is a system that allows all VHA facilities, VISNs and headquarters offices to be connected via e-mail. This project was the first of its kind to focus directly on the implementation of "One VA" to tie all of VA (VBA, VHA, and NCA) together with one electronic mail system. It not only required close coordination and cooperation from VHA facilities but also was completed in coordination with similar projects being done in VBA and Headquarters.

Plans for 2000 – 2005

- Expect installation of Windows 2000 to begin late in 2000. Additional hardware will be needed to support this software, which would either be purchased as part of a central contract developed in concert with the networks, or would require cooperative purchases within networks to ensure standardized performance and capabilities.
- Expect upgrades to Exchange 2000 late 2000. Hardware upgrades will also be required to replace equipment that will be 3 – 4 years old. These would either be purchased as part of a central contract developed in concert with the networks or would require cooperative purchases within networks to ensure standardized performance and capabilities.
- Complete installation of ScanMail Version 3.0 by the 3rd Quarter of 2000. This will allow staff to scan mail on a local level.

1998 & 1999 Achievement Highlights

- Completed selection of vendor to install Exchange V5.5/SMS2.0/MS Clustering Service system-wide.
- Completed initiative to place facility generic mailboxes on all facility Exchange servers. This fulfills the need to have routine correspondence sent to a generic mailbox that will be monitored by local staff. This eliminates routine information being sent directly to network or medical center directors' personal Exchange mailboxes.
- Completed installation of ScanMail Virus Protection software for MS Exchange attachments on all Exchange servers within VHA. The software self-updates once per week and can be managed centrally.
- Added approximately 90,000 users to the Global Address List.
- Completed the upgrade to Exchange software V5.5, SMS V2.0 and MS Cluster Service.
- Upgraded ScanMail and VirusWall to protect the VA electronic mail system from various virus attacks, such as Melissa.

Internet/Intranet Functionality Project

VHA continues to improve communication among veterans, employees, and other stakeholders by expanding and enhancing Internet and Intranet capabilities. VHA maintains both an Internet, targeted for external customers, and an Intranet, for employees. VHA's Internet and Intranet projects support the organizational goal of "One VA." VHA efforts are consistent with the VA objective of establishing and maintaining the Corporate Information Repository (CIR). VHA Intranet website was built to provide a single source of corporate information for users at any organizational level, and is accessible to VHA employees systemwide.

Gathering information that meets the needs of different target audiences, organizing it well, and making it readily available to all veterans, employees, and other stakeholders is a fundamental premise of VHA's Internet/Intranet initiatives. VHA has launched a Veteran Focused Internet Redesign Project (VFIRP), directed towards the creation of a single web presence to improve veteran's access to VA information. This "One VA" effort has representation from all VA elements, and the result will enable veterans to easily find VA information they need presented in a way they can understand and use.

VHA also is exploring and piloting technologies such as Virtual Private Networks (VPNs), the Public Key Infrastructure (PKI), and Smart Cards that will provide the technical underpinnings and security functions to support secure, web-based, information exchange and electronic service delivery. These initiatives are also being coordinated with other elements of the agency and undertaken as "One VA" initiatives. Accomplishing these goals will improve service to veterans and their families and provide an important knowledge management component for today's virtual working environment.

Plans for 2000 – 2005

- Develop the "site-in-a-box" concept. This will include establishing a tool set of the most popular web applications that can be included on any website. VHA customers will be able to easily personalize the application to address the individual needs of a program office, VISN, or facility environment.
- Develop an awareness campaign to inform VHA customers of what is available on the Intranet, and what services are offered to help develop or improve their web presence.
- Develop policies and guidelines for developing, maintaining, and governing the VA Internet website in conjunction with other VA administrations and program offices.

1998 & 1999 Achievement Highlights

- In 1998, implemented a communications protocol (secure socket layer) to protect privacy of individuals interacting with VA Web servers on Internet.
- In 1999, increased security and integrity of the VA Web services by implementing a protection firewall.
- In 1999, expanded and improved VHA's Intranet design to provide customizable home page and dynamic content.

Information Sharing Among and Between VA Organizational Elements

Automated Medical Information Exchange (AMIE) Phase II

The AMIE system was developed in the mid-1980's when most VHA medical records were stored in paper form. VHA has rapidly increased electronic storage of medical information and the information link between VBA and VHA has shifted away from paper to mutual accessibility of electronic records. AMIE II supports that process and is an initiative that:

- Upgrades and shares communications linkages
- Capitalizes on VHA's electronic storage of medical information

- ❑ Allows VA medical facility staff full read access to the Benefits Delivery Network (BDN)/TARGET system for veteran eligibility inquiries
- ❑ Allows VBA staff access to medical data in VHA's ***VistA*** system

Mutual accessibility of electronic records significantly reduces redundant labor intensive process in both agencies. AMIE II enhances the way we conduct business and how work is processed within both agencies.

Plans for 2000 – 2005

- ♦ All AMIE software has been implemented and the AMIE project remains unchanged since 1998.

1998 & 1999 Achievement Highlights

- ♦ Satellite broadcast of the AMIE II initiative to over 600 VBA and VHA staff.
- ♦ VBA identified an AMIE super user and liaison at each regional office and VHA did the same at their medical centers.
- ♦ All VHA medical centers and all VBA regional offices installed all components of AMIE II.

Increasing the Availability of Electronic Patient Medical Information Between Facilities

This section discusses several projects underway to enhance the management of patient care. The Clinical Information Resources Network (CIRN) is the system (analogous to a mail system) that is the conduit of data to and from the Computerized Patient Record System (CPRS). The Government Computer Based Record is in a very early stage of development. It will set government-wide standards for patient records.

Master Patient Index/Patient Demographics (MPI/PD) / Clinical Data Repository

Access to patient information is a crucial element in VHA health care delivery. Cross referral of patients within and among VISNs will become a standard method of providing managed care. It is a system for providing up-to-date clinical and demographic data automatically to facilities. This network provides the ability to identify and track all locations where patients are receiving care and implements a VHA Master Patient Index to enable consistent updates of patient demographic data.

During 1999, the scope of the CIRN project was changed to reflect new directions for creation of an enterprise-wide clinical data repository. CIRN was divided into two projects: the Master Patient Index/Patient Demographics (MPI/PD) project and the Clinical Repository (CR) project. The CR project was created to continue the clinical portion of CIRN. This project is being re-examined in light of technology changes and to evaluate the potential use of commercial systems.

The MPI/PD will support primary care on a network-wide basis as an integrated component of the CPRS Clinician desktop. MPI/PD consists of the implementation of software/procedures needed for facilities to clean up their databases and the implementation of the Master Patient Index (MPI), which is used to uniquely identify patients and track in real time, all locations where they have received care.

Plans for 2000 – 2005

- Provide development and implementation support of the MPI/PD project. Both Customer Services and Implementation and Training Services will assist Technical Services with the implementation of MPI/P in the VISNs.
- Analyze the DoD/IHS commercial clinical repository solution. The analysis will also include a review of in-house development efforts to create a clinical repository utilizing new tools and platforms.
- Pursue a prototype demonstration of a Caché Objects Repository. Deliverables include a set of tools to extract clinical data from existing ***VistA*** files and development of an HL7 Interface. A Clinical Object Dictionary Interface will be developed.
- Develop a formal proposal with the actions required to move forward with a new clinical repository for ***VistA*** (4th quarter of 2000).

1998 & 1999 Achievement Highlights

- In 1998 and revised in 1999, developed the national implementation plan for MPI/PD and CR.
- In 1998 and revised in 1999, developed national CIRN training plan for MPI/PD and CR.

PROJECT IMPLEMENTATION SCHEDULE

Pre-Implementation Phase:	Completed pre-implementation and patient merge tasks in October 1998.
MPI/PD:	Released nationally by September 30, 1998; MPI/PD implemented nationally by July 2000.
CR:	Complete evaluation of alternatives for clinical repository by July 2000.

The Computerized Patient Record System (CPRS)

The computerized patient record system (CPRS) is a comprehensive software application that gives health care providers an automated view of a patient's medical record. CPRS integrates a variety of ***VistA*** software applications to provide a single interface to view existing information or place new orders for a patient. Use of CPRS facilitates textual and coded documentation of a patient encounter, including the recording of diagnosis and procedure codes as well as response to clinical practice guidelines.

CPRS meets IT strategic needs by improving information sharing between VA organizational elements, increasing the availability of electronic patient medical information within and between VA facilities, and expanding decision support capabilities for health care providers.

Plans for 2000 – 2005

- Release national screening reminder for patients at risk for Hepatitis C in 2nd Quarter 2000.
- Upgrade CPRS GUI to allow responses to clinical practice guidelines via point and click interface which automatically generates note text, codified encounter data, and orders. Clinical Reminder v1.5 and associated CPRS GUI update are currently in test at Boston/Brockton, Fargo, Saginaw, Salt Lake City, San Antonio, San Diego, Tampa, Tuscaloosa, Washington, DC, and West Palm Beach. Plan for national release in 3rd Quarter 2000.
- Streamline process for ordering medications in CPRS with the CPRS GUI interface to be completed by the end of 3rd Quarter 2000.

1998 & 1999 Achievement Highlights

- Installed CPRS at 136 VA facilities and completed installation for remaining facilities in 1999.
- Completed 'Camp CPRS' national training conferences. In 1999, 150 campuses attended the national training conferences and in 1998, 147 campuses attended.
- Included the enhanced ordering functionality in CPRS Graphical User Interface (GUI) including event delay ordering, creation and use of order sets, and updates to lab ordering.
- Intranet website developed which contains latest CPRS updates, answers to frequently asked questions, and CPRS tutorials in a single location. (VISN 20)

The Government Computer-Based Patient Record (G-CPR)

The Government Computer-based Patient Record (G-CPR) Framework Project is a collaborative federal health care initiative. VA, DoD, and Indian Health Service (IHS) are the current participants. The G-CPR project includes the design, development, and implementation of the standards, technical framework, data, hardware, and software architecture required to achieve an easily accessible, yet secure, life-long medical record for each of our Nation's veterans, military personnel, their dependents, and Native Americans. Technologies and standards will enable the exchange of clinical information on a shared patient population, consistent with patient privacy and confidentiality. The primary vision of this readily accessible record is to improve public and individual health status by sharing clinical information. Where no standards exist, the partnership will seek to advance the development, establishment, and adherence to standards in their collaborative effort to appropriately share clinical information.

The G-CPR Framework Project will enhance the quality of care clinicians provide to patients by facilitating the exchange of patient medical information between various cooperating sites where health care is being delivered. The Framework design also provides the potential to link private sector contract providers with the Framework to share secured clinical information between the private sector and the federal participants.

The G-CPR Framework components are:

Security. Security functions are among the most visible functions of the G-CPR Framework. All access to information will be through secure gateways that identify and authenticate all framework "users," whether they are people, existing and future systems, or medical devices. Highly visible is the first point of integration with the G-CPR Framework; these security functions also permeate all the other functional layers. The security requirements will be supported by mature technologies. The key features of the security include:

- Single sign-on and role-based security
- C2 compliance
- Mechanisms that are transparent and unobtrusive
- Support for Medical Information Privacy and Security Act and HIPAA
- Certificate-based data encryption that is DoD/GSA/PKI-compliant
- Rigorous identification and authentication at all interface points

Infrastructure/Middleware. This component provides the ties necessary to connect the external interfaces to the Data Management Region. It controls low-level processing activities such as internal communications, message handling, trigger event dispatch, and higher-level brokering services and resources. Most users will never be aware of this component.

Data Management/Common Reference Models. Data management is the element of the G-CPR Framework architecture that provides users and applications distributed access to data throughout the G-CPR Partner systems. This access is generally in the form of queries that are executed by a user or an application (e.g., a doctor's request to retrieve a patient's medical records or an application developed to conduct population studies or retrospective analysis). The data management element also provides the implementing mechanisms to model and transform information across the G-CPR enterprise. It is here that the G-CPR Reference Models for information and terminology are utilized. The primary components of the data management architecture are Query Services, Common Data Representation, Master Patient Information Locator, Virtual Database and Cache/Storage Management.

The Common Data Representation in the G-CPR Framework depends upon semantic mediation, which in turn relies on a coded, concept-based vocabulary. Each concept in the Common Data Representation is assigned a unique identifier, enabling the Framework to deal with the semantics or meaning of a piece of data, not its linguistic representation. The mediation services assist in transforming the syntax and semantics of the source system data to that of the target systems.

Plans for 2000 – 2005

- Accomplished data retrieval from the heritage systems in the building of the Proof-of-Concept in a laboratory setting. Technical mapping has been accomplished to identify domains in the three heritage systems. More extensive mapping will be developed for a fully functional system.
- Pursue initial testing of G-CPR at the Alaska Native Medical Center, Department of Veterans Affairs Medical Center, and Elmendorf Air Force Base Military Treatment Facility and other federal health care facilities in Alaska.
- Conduct Phase II Pilot testing of the Framework. Alpha testing scheduled for 2001 in Alaska includes interagency sharing of demographic data, laboratory results, medication profiles, and allergy and immunization information, as well as other important and pertinent health care data. Analyze site infrastructure, process change, resource, and training and implementation requirements at Alpha/Beta test sites. Develop plans for incremental deployment by the participating agencies of new functionality and the technical solution. Establish Beta test sites.

1998 & 1999 Achievement Highlights

- Established functional, technical and clinical workgroups. They include government lead interagency workgroups, prime contractor lead Integrated Product Teams (IPTs) and agency specific technical teams.
- Developed use-case models during participation in a set of facilitated workshops and using interactive collaboration and communication tools. Modeling was completed for Person Partition, Patient Record Architecture Partition, Security Partition, Continuity of Care Partition, and Clinical Observations Access.
- Completed a baseline Reference Terminology Model (RTM). The RTM defines the terminology mapping requirements for each of the initial domains identified.

Imaging Project

The VA's ***VistA*** Integrated Imaging System captures clinical images, scanned documents and other non-textual data files and makes them part of the patient's electronic medical record. The system provides a tool for communication and consultation among clinicians in the same department, in different services, or at different facilities across the country. Use of the system will enable VA to eventually operate in a "filmless" mode with electronic access to all veteran patient "images" (i.e., radiology, cardiology, dermatology, pathology, surgery, etc.) for diagnostics and education from virtually any location.

This revolutionary system supports the goal of delivering the highest quality health care available, which supports the mission goals of the "new VHA" as defined in the *Prescription for Change*. The ***VistA*** Imaging System project also supports the VA Strategic Plan, which includes a goal to expand telemedicine activities to improve access to care, (e.g., telepathology, telenuclear medicine, teleradiology, telepsychology, teledermatology, teledentistry).

Plans for 2000 – 2005

- Release ***VistA*** Imaging Clinical, Radiology and DICOM interface components and teleradiology components for system implementation.
- Demonstrate the multimedia electronic patient record at the RSNA and the HIMSS meetings in 2000.

1998 & 1999 Achievement Highlights

- Released three ***VistA*** Imaging software applications: Laboratory Electronic Data Interchange, Text Integration Utilities, and Authorization / Subscription Utility.
- Implemented 40 sites in 14 VISNs requesting ***VistA*** Medical Imaging.
- Tested the Radiology Reading Workstation software under Windows NT. Changes to software made substantial improvements in performance. Training was provided for the radiologists using the reading workstation at the Washington, DC VAMC and at St. Louis.
- Created an interface to the GE PACS system. Several VAMC sites are now using this functionality.
- Completed ***VistA*** Imaging version 2.5. A link between the Text Integration Utility (TIU) and ***VistA*** Imaging allows images to be associated with Progress Notes and Consults. Users want this capability for use with clinical images such as home-based patient care images and with scanned documents such as advanced directives and consent forms. Other changes in this version included radiology image measurement, improved image capture, and enhanced DICOM gateway and background processor functions.
- Improved Radiologist productivity through enhancements to ***VistA*** Imaging version 3.0 (***VistA*** Rad). Management of Unread Radiology Studies was improved and radiologists can now customize these lists. Images from previous related studies can be prefetched from long-term storage to increase display and reading speed. The number of simultaneous studies that can be read has been increased. Modifications were made to improve file access security and to improve measurements, ROI/Hounsfield statistics, Multiple Exam Lists Display, scrolling within an exam and window/level functions.

EXPANDING SUPPORT FOR ADMINISTRATIVE DECISION MAKING

Decision Support System (DSS)

The Decision Support System is an executive information system that provides data on the patterns of care and patient outcomes linked to the resource consumption and costs associated with the health care process.

Plans for 2000 – 2005

- Focus on training end user senior management and headquarters staff to effectively use the system.
- Capture Non-VA workload, Resource Management System, DSS utilization for the VERA in 2002, Physician Profiling, and advanced Management Use and Clinical training.
- Continue transitioning from the Cost Distribution Report to DSS in collaboration with the Chief Financial Office (CFO).

1998 & 1999 Achievement Highlights

- Completed technical implementation of DSS at all sites during 1999 and DSS is being used by 100% of VHA health care facilities.
- Generate and distribute monthly reports by VISN / facilities the types of data that have been submitted to AAC for processing.
- Established the DSS Special Assistance Team (SAT) composed of experienced DSS implementation managers who serve as consultants to the field.
- Defined standardization as it related to the DSS structure, such as the common department groups, and not the actual workload.
- Received approval from the National Leadership Board (NLB) for the establishment of an Access Subcommittee to formulate policy on access to DSS data.
- Obtained agreement from the Practice Management Advisory Board to be the source of information for the Practice Management effort.

CONCLUSION

Improving information technology and architecture in order to provide world class support to our customers is an ever changing and evolving process. This evolution has resulted in enormous opportunities to improve the quality of patient care, to improve cost effectiveness, and to enhance both administrative and clinical decision making in information technology. VHA continues to lead the way in the IT health care arena. An example previously described in Chapter 3, *Patient Safety Initiative*, was bar coding medication administration information. For VHA, the goal is to seek out, evaluate, embrace and use new technology to better serve the Nation's veterans and to provide them with the very highest quality of services and health care.

Chapter 10

Conclusion – VHA in the 21st Century

American health care is remaking itself. Powerful societal, demographic, and industry-wide forces of change are rapidly transforming American health care. There is not yet in the United States of America, or in any other country of the world, a health care system that fully satisfies all the demands for access, quality, user service, and cost. However, the veterans health care system as the Nation's largest integrated health care system has achieved more than any other system in this regard. It is not only the largest fully integrated health care system in the U.S., but it is also the most complex health care system in the world because of its multiple missions – health care, education, research, and emergency management.

VHA Reengineering

Non-health care industries facing challenges similar to what health care has faced in the 1990s have found that those organizations that provide high quality products and services for an affordable cost (i.e., those which provide the best value) are the ones most likely to survive and thrive in a changing environment. Providing excellent health care value has been the central tenet to the transformation of the veterans health care system.

Much about VHA's reengineering has charted new territory, since no established health care system of VHA's size and complexity has ever accomplished such a radical change. Likewise, no public agency having the complexity of missions and the political sensitivity of veterans' health care has ever changed so quickly. There are no directly comparable models for accomplishing such a reengineering effort. VHA's reengineering has progressed in three phases so far. These have occurred at differing rates in different parts of the system; these phases are not precisely defined or completely distinct from each other.

Phase 1 of VHA's reengineering began in late 1994 when Kenneth W. Kizer, M.D., M.P.H. became VHA's Under Secretary for Health and continued through the end of 1995. This phase consisted of:

- Analyzing the future
- Defining the problems of the "old VA"
- Describing a vision of the "new VA"
- Developing a plan for transforming the system
- Gaining consensus on that plan, which included six months to secure Congressional approval
- Creating new programs and hiring new staff, as well as eliminating programs that were no longer needed
- Laying the groundwork for changes actualized in the next phase

Phase 2 began in early 1996 and continued through 1998. This phase has been characterized by:

- Operationalizing the new Veterans Integrated Service Network (VISN) management structure with its more decentralized decision-making processes
- Implementing and validating a new capitated resource allocation system, with its attendant funding shifts among VISNs and its inherent incentives to improve operational efficiency and access
- Substantially changing the manner in which services are provided (e.g., implementation of universal primary care, the shift from inpatient to outpatient care, establishment of community-based outpatient clinics, inauguration of regional and multi-institutional service lines)
- Implementing a pharmacy benefits management program, including a national formulary
- Restructuring VHA's education and research programs
- Reducing the number of total personnel to increase efficiency and redirect resources to provision of patient care services
- Implementing landmark eligibility reform legislation with its myriad consequent effects, including establishment of a formal enrollment system
- Merging and integrating facilities into health care systems
- Markedly expanding and modernizing information management capabilities, including systemwide implementation of a new cost accounting and clinical management system
- Initiating fundamental and far-reaching changes in personnel practices, program functions, and performance assessment

Given the intrinsic inertia in a bureaucracy as large as VHA and with as many sources of internal and external resistance to change, a substantial degree of centralized direction has been necessary to launch VHA's operational transformation and to establish the foundation for a new organizational culture. Not surprisingly, this amount of rapid change with its requisite central direction has produced significant turmoil, anxiety, and uncertainty among staff and stakeholders. At the end of 1998, VHA entered Phase 3 of the reengineering effort.

- Many new ways of doing business are fully operationalized and are being refined according to early experience with them
- The new organizational culture that was born in Phase 2 is growing and maturing in Phase 3
- Change is continuing, but the nature of the change is somewhat less intense as the organization assimilates the many new ways of doing business that were initiated in Phase 2 and as the new organizational culture is maturing
- It is a period characterized more by bottom-up refinement and adjustment than by the top-down, radical changes initiated in Phase 2; quality transformations, patient safety improvements, and information technology are the defining characteristics of Phase 3

VHA's current reorganization efforts are not a simple realignment of its myriad physical assets, nor a simple reshuffling of bureaucratic boxes on an organizational chart. Instead, these efforts represent a fundamental change in the way responsibility is spread throughout the organization, what practices and behaviors are nurtured and rewarded, and how care will be provided in the future. As such, the change has not occurred immediately or easily. Nonetheless, for the system to remain viable in the long term, systemic change has to occur.

VA Health Care in the 21st Century

Just as VA and private sector health care have been influenced by multiple forces of change during the past four years, they will continue to be subject to these same forces of change in the future. However, there are a number of reasons to believe their effect or influence may be even more pronounced in the future than in the past decade.

As VA looks to the future, the projected changes in the veteran population must be monitored. Assuming no new large scale military engagements occur, the veteran population is expected to decline from 25.1 million in 1998 to 23.1 million in 2003 and to about 20 million in 2010. However, while the absolute number of veterans is projected to decline in the future, the characteristics of the veteran population served by VA will actually result in higher demand for health care services. In particular, this is because the veteran population is aging, becoming more female, and is increasingly mobile.

Compared to private sector patients, VA's patients are older, more likely to be disabled and unable to work, less educated, poorer, and less likely to have health insurance or families. These characteristics will result in a disproportionately greater need for services among VA's service population than the general public in the future.

The veterans health care system will continue to evolve and as a result of the changes made to date should be well positioned to expand its services should policy decisions dictate. Underlying such policy decisions will be the central issue for health care everywhere – i.e., the need to provide health care value. The essential mandate for health care providers continues to be to demonstrate good value. VA has operationalized, or defined, health care value as being the composite of achieving easy access, high technical quality, service satisfaction, and optimal patient functionality at a reasonable cost.

VA will get better at what it now does – i.e., taking care of service-connected and poor veterans in a system that not only provides current state-of-the-art medical care, but one that also trains tomorrow's health care providers and one that researches and pioneers tomorrow's health care solutions. Finding better ways of caring for VA's population of chronically ill, older and poorer veterans will ultimately result in better care for all Americans.

In pursuing this direction, VA must adhere to six key principles:

- Its business is ***health care*** not hospital care and at its core is providing for special care needs of service-related veterans
  - Treat spinal cord injured veterans
  - Provide prostheses and blind rehabilitation
  - Treat PTSD and environment exposure problems
  - Provide service related care for veterans that may not be readily found in the private sector

- Concentrate on ***managing care*** not costs
  - Concentrate on managing the care of complex, chronic conditions of an increasingly elderly veteran population
  - Make care more coordinated, more convenient, and more coherent, i.e., to manage care so that it actually improves outcomes

- Provide ***consistent*** and ***predictable*** high quality care
  - Reduce unexplained or inappropriate variation in service across the system
- Continually examine and improve processes to create a culture to support patient and employee ***safety***
- Continually improve ***information*** and ***data management***
  - Information should be patient-centered and uniformly available across the system instead of facility-based
- Be comfortable with continuous, rapid ***change***
  - The rate and pace of change in health care is accelerating
  - Scientific and technological underpinnings of medical care are changing at an unprecedented rate
  - Biggest challenge will be having organizational management and financial structures that can adapt as rapidly as medical science evolves

In the past, the veterans health care system was too insular, too introspective, and too isolated. VA's future viability will be enhanced by forging relationships with others – others that have had less exposure to and less understanding of veterans and military issues. These relationships will increase understanding of the value and benefits of maintaining a publicly funded, direct care system that has as its primary mission providing care for the men and women who have served in the military for this country.

Glossary of Acronyms

ABT:	Antibiotic Treatment
ACT:	Assertive Community Treatment
ADHC:	Adult Day Health Care
AHP:	Analytical Hierarchy Process
AIDS:	Acquired Immune Deficiency Syndrome
AL:	Assisted Living
ALF:	American Liver Foundation
AMA:	American Medical Association
AMIE:	Automated Medical Information Exchange
ASI:	Addiction Severity Index
BDN:	Benefits Delivery Network
BDOC:	Bed Days of Care
BROS:	Blind Rehabilitation Outpatient Specialist
C&P:	Compensation & Pension
CARED:	Caregiver Assessment Regarding End-of-Life in Dementia
CARES:	Capital Asset Realignment for Enhanced Services
CARF:	Commission on Accreditation of Rehabilitation Facilities
CBOC:	Community Based Outpatient Clinic
CCSCMI:	Committee on Care of Severely Chronically Mentally Ill Veterans
CESATE:	Center of Excellence in Substance Abuse Treatment
CFO:	Chief Financial Office
CHALENG:	Community Homelessness Assessment, Local Education & Networking Groups
CHF:	Congestive Heart Failure
CICD:	Center to Improve Care of the Dying
CIR:	Corporate Information Repository
CIRN:	Clinical Information Resources Network
CME:	Continuing Medical Education
CMT:	Centralized Means Testing
COOP:	Continuity of Operations Plan
COPD:	Chronic Obstructive Pulmonary Disease
COURAGE:	Clinical Outcomes Utilizing Revascularization & Aggressive Drug Evaluation
CPRS:	Computerized Patient Record System
CPT:	Current Procedural Terminology
CR:	Clinical Repository
CSS:	Customer Service Standard

DCHV:	Domiciliary Care for Homeless Veterans
DoD:	Department of Defense
DSS:	Decision Support System
DU:	Depleted Uranium
DVHIP:	Defense and Veterans Head Injury Program
EAS:	Environmental Agents Service
EBT:	Exercise / Behavioral Therapy
EES:	Employee Education System
EMSHG:	Emergency Management Strategic Healthcare Group
EPI:	Emerging Pathogens Index
ERPST:	Eligibility Reform Performance Support Tool
ESRD:	End Stage Renal Disease
FES:	Functional Electrical Stimulation
FSOD:	Functional Status and Outcomes Database
GAF:	Global Assessment of Functioning
G-CPR:	Government Computer-based Patient Record
GEM:	Geriatric Evaluation Management
GRECC:	Geriatric Research, Education and Clinical Center
GUI:	Graphical User Interface
HBPC:	Home Based Primary Care
HCFA:	Health Care Financing Administration
HCV:	Hepatitis C Virus
HEC:	Health Eligibility Center
H/HHA:	Homemaker/Home Health Aide
HHS:	Department of Health and Human Services
HPDM:	High Performance Development Model
HSR&D:	Health Services Research & Development
IHD:	Ischemic Heart Disease
IHI:	Institute for Healthcare Improvement
IHS:	Indian Health Service
IMPAC:	International Merchant Purchase Authorization Card
IOM:	Institute of Medicine
IPT:	Integrated Product Teams
ISMP:	Institute for Safe Medication Practices
IT:	Information Technology
JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
MCCF:	Medical Care Cost Fund
MD:	Medical Doctor
MOA:	Memorandum of Agreement

MOU:	Memorandum of Understanding
MPI/PD:	Master Patient Index / Patient Demographics
MTS:	Means Test Sharing
NCA:	National Cemetery Administration
NCPS:	National Center for Patient Safety
NDMS:	National Disaster Medical System
NED:	National Enrollment Database
NLB:	National Leadership Board
NPDFC:	National Performance Data Feedback Center
NPPD:	National Prosthetic Patient Database
NPSP:	National Patient Safety Partnership
NRM:	Non-Recurring Maintenance
NSC:	Non-Service Connected
OAA:	Office of Academic Affiliations
OI:	Office of Information
OIFO:	Office of Information Field Offices
OMB:	Office of Management and Budget
OPC:	Outpatient Clinic
PAC:	Presidential Advisory Committee
PACT:	Preservation/Amputation Care and Treatment
PAR:	Peer Assistance Residence
PCMM:	Primary Care Management Module
PERC:	Program Evaluation and Resource Center
PKI:	Public Key Infrastructure
PL:	Public Law
POW:	Prisoner of War
PPRP:	Prosthetic Program Reinvention Program
PRP:	Pro-Rated Person
PSAS:	Prosthetics and Sensory Aids Service
PSRS:	Patient Safety Reporting System
PTH:	Parathyroid Hormone
PTSD:	Post Traumatic Stress Disorder
QUERI:	Quality Enhancement Research Initiative
REAP:	Research Enhancement Awards Program
REGO:	Reinventing Government
RRRC:	Residency Realignment Review Committee
RTM:	Reference Terminology Model

SAT:	Special Assistance Team
SC:	Service Connected
SCI:	Spinal Cord Injury
SCI&D:	Spinal Cord Injury & Disorders
SEAT:	Service Evaluation & Action Team
SEP:	Special Emphasis Program
SMI:	Seriously Mentally Ill
SOP:	Standard Operating Procedures
TBI:	Traumatic Brain Injury
TEMPO:	Training and Education Management Program
TIU:	Text Integration Utility
USH:	Under Secretary for Health
VA:	Department of Veterans Affairs
VACIB:	VA Capital Investment Board
VAF:	VA Form
VAHQ:	VA Headquarters
VAMC:	VA Medical Center
VBA:	Veterans Benefits Administration
VERA:	Veterans Equitable Resource Allocation
VFIRP:	Veteran Focused Internet Redesign Project
VHA:	Veterans Health Administration
VISN:	Veterans Integrated Service Network
VIST:	Visually Impaired Service Team
VistA:	Veterans Health Information Systems & Technology Architecture
VPN:	Virtual Private Network
VPR:	VISN Prosthetics Representative
WAN:	Wide Area Network
WATCH:	Warfarin and Antiplatelet Therapy in Congestive Heart Failure
Y2K:	Year 2000

Strategic Framework for Quality Management

DIMENSION	STRATEGY	TACTIC
I **PERSONNEL**	To attract and retain the best people possible.	• Credentialing (board certification, licensure) • Workplace environment • Mentoring • Academic affiliations • Workplace environment • Performance-based interviewing
II **CLINICAL CARE ACTIVITIES**	To employ clinical care activities that increase the likelihood of achieving desired health outcomes.	• Primary care • Telephone linked care • Utilization management • Community-based services and home care • Care/case management • Practice guidelines/clinical pathways • Shared decision making • Palliative care • Practice profiling • Transplant review boards • Contract specifications • Programs of excellence

III
 	
PERFORMANCE INDICATORS
	To measure and monitor progress in achieving desired health outcomes.	• Prevention Index
		• Chronic Disease Care Index
		• Palliative Care Index
		• Spinal Cord Injury Index
		• Surgical morbidity and mortality rates
		• Medical cohort survival rates
		• Long Term Care Index
		• Functional Outcome Measures
		  o SF-36
		  o Functional Independence Measure
		  o Addiction Severity Index
		• Special Program Outcomes
		• Mental health performance indicators
		• Case Registries (examples)
		  o Cancer
		  o Spinal Cord Injury
		  o Immunology/HIV
		  o Clozapine
		  o Positron Emission Tomography (PET)
		  o Agent Orange Health Examination Program
		  o Gulf War Health Examination Program
		  o Ionizing Radiation Registry Examination Program
		• Occupational Safety and Health Index
		• Financial management report cards
		• Performance Measures Work Group

IV
 	
INTERNAL REVIEW & IMPROVEMENT
	To engage all levels of the organization in both routine and event-triggered cycles of improvement.	• Clinical pathology conferences
		• Morbidity & mortality conferences
		• Ad hoc review teams
		• Process action teams
		• Pharmacy and Therapeutics Committees
		• Bioethics Committee reviews
		• Patient Safety Sentinel Events Registry
		• Causation analyses
		  o Focused Reviews
		  o Boards of Investigation
		  o Root cause analyses
		• Tort claims analysis
		• Patient Safety Oversight Committee
		• Technical advisory groups (e.g., Dialysis)
		• National Formulary/Pharmacy Benefits Management Strategic Healthcare Group
		• National Surgical Quality Improvement Program
		• Surgical consultant committees (e.g., cardiac, neurosurgery)
		• Quality Management Officer reviews
		• Baldrige assessments
		• VISN Quality Forums
		• Benchmarking
		• Employee feedback
		• Quality councils
		• Quality-related advisory committees (e.g., Committee on Case of Severely Chronically Mentally Ill Veterans
		• Office of the Medical Inspector

V
 	
EXTERNAL REVIEW & OVERSIGHT
	To enlist impartial and independent review of care.	• Accreditation and Certification
		  o Joint Commission on Accreditation of Healthcare Organizations
		  o Rehabilitation Accreditation Commission
		  o National Committee on Quality Assurance
		  o American College of Surgeons
		  o American College of Radiology
		  o College of American Pathologists
		  o American Association of Blood Banks
		  o American Psychiatric Association
		  o American College of Nuclear Physicians
		  o Food and Drug Administration (FDA) Division of Mammography Quality and Radiation Programs
		  o Nuclear Regulatory Commission
		  o Accreditation Council for Graduate Medical Education
		  o Quality Management Advisory Panel
		• Quality-related advisory committees (e.g.)
		  o Geriatrics and Gerontology Advisory Committee
		  o Persian Gulf Expert Scientific Committee
		  o Advisory Committee on Prosthetics and Special Disabilities Programs
		  o Expert Advisory Panel and Patient Safety System Design
		  o Advisory Committee on the Readjustment of Veterans
		  o Advisory Committee on Women Veterans
		  o Future of VA Long-Term Care Advisory Committee
		  o Special Medical Advisory Group
		• External peer review (contracted)
		• Office of the Inspector General (Department of Veterans Affairs)
		• General Accounting Office
		• Veterans service organizations
		• Academic affiliates
		• Congress
		• Press/media

VI **TECHNOLOGY MANAGEMENT**	To optimize use of technology to achieve desired health outcomes.	• Decision support aides • Quality system survey • Electronic medical record • Medical record direct patient input • Technology Recommendations Panel

VII
 	
PATIENT-REPORTED OUTCOMES
	To optimize patient and patient family involvement in the design and delivery of health care services.	• Focus groups
		• Customer Satisfaction Surveys
		  o Inpatient
		  o Outpatient
		  o Persian Gulf
		  o Spinal Cord Injury
		  o Home-based Primary Care
		  o Prosthetics
		• Complaint Handling
		• Patient Advocates
		• Service Evaluation and Action Teams

VIII
 	
EDUCATION
	To prepare the current and future health care work force to deliver high quality health care and to actively participate in improving care.	• Health professional training (academic environment)
		• Workforce development
		  o 360º personnel evaluations
		  o continuing education
		• Quality scholars & fellowships

IX
 	
RESEARCH
	To generate new knowledge that facilitates improved health outcomes.	• Health services studies
		• Clinical care studies
		• Biomedical studies
		• Technology assessment
		• Quality-related research advisory committees
		  o Medical Research Service Cooperative Studies Evaluation Committee
		  o Medical Research Service Merit Review Committee
		  o Scientific Review and Evaluation Board for Health Services Research and Development
		  o Rehabilitation Research and Development Service Scientific Merit Review Board

X **CHANGE MANAGEMENT**	To actively manage change to achieve strategic goals.	• Executive performance agreements • Quality Management Integration Council • Resource allocation strategy (VERA) • Standardization of language • Integrated collaborative planning • VA Quality Award (e.g., Robert W. Carey Award, Scissors Award) • USH/VHA Quality Improvement Awards (e.g., Best Value Award, Strategic Alliance Awards, Quality Improvement Award, Superior Customer Service Awards, others) • Patient Safety Improvement Awards • Quality Achievement Recognition Grant • External Awards (e.g., Hammer Award, President's Award for Quality, professional organization awards, community awards)